RENSSELAER COUNTY
DEPARTMENT OF MENTAL HEALTH

Steven F. McLaughlin
County Executive

Katherine G. Alonge-Coons LCSWR
Commissioner

NOTICE OF PRIVACY PRACTICES
NEW YORK STATE'S "SURPRISE BILL" LAW,
RECIPENT RIGHTS,
CONSENT FOR TREATMENT

I acknowledge that I have read the Rensselaer County:

Notice of Privacy Practices,
New York State's "Surprise Bill" Law
Recipient Rights
Hixny Consent
PSYCKES Consent

I also consent to the disclosure of personally identifiable information for treatment, payment and normal healthcare business operations of the covered program in regard to myself and others noticed below for whom I can legally consent.

I understand I may request a copy of these policies at any time throughout my episode of care.

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

I, or my minor child _____ accept, understand and agree to abide by the contents and terms of this agreement, and further, consent to participate in the evaluation and/or treatment. I understand that I may withdrawal from treatment at any time.

_____
Printed Name of Enrollee/Patient

_____
Signature - describe legal relationship to others

_____
Date

"Providing quality care to empower and help all persons."

NED PATTISON RENSSELAER COUNTY GOVERNMENT CENTER
1600 7th AVENUE, TROY, NEW YORK 12180
PHONE: (518) 270-2800 FAX: (518) 270-2723

Hixny

Hixny Electronic Data Access Consent Form

Rensselaer County Department of Mental Health

In this Consent Form, you can choose whether to allow **Rensselaer County Department of Mental Health** 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 **Rensselaer County Department of Mental Health** 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, **Rensselaer County Department of Mental Health'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, **Rensselaer County Department of Mental Health** 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 Rensselaer County Department of Mental Health 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 Rensselaer County Department of Mental Health 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)

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

Consent Form

Rensselaer County Department of 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").

RENSSELAER COUNTY DEPARTMENT OF MENTAL HEALTH Rev 12.4.17

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse; the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV information and you may request a list of persons authorized to re-release such information. The information exchanged may be verbal or written.

Name or Title of person or organizations releasing and/or obtaining information:	Name or Title of person or organizations releasing and/or obtaining information:
Between:	And:
_____	Rensselaer County Department Mental Health
_____	Ph 518-463-8869 . Fax 518-463-8733

1. Description of information including date(s): ALL PERTINENT

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information ___ Genetic testing information

___ Mental health information ___ Drug/alcohol diagnosis, treatment, or referral information

2. Purpose of the use/disclosure: COORDINATION OF CARE.

3. The person/program requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

4. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for payment, enrollment, etc.

5. I understand that I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it.

6. I may remove this authorization at any time by notifying the Rensselaer County Dept. of Mental Health in writing, but if I do it will not have any effect on any actions they took before they received the revocation.
This authorization will expire: Upon Discharge from Care

HIV specific information:
For questions/complaints regarding HIV discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

Federally protected substance abuse information:
I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of Patient or legal representative: _____ Date: ___/___/___

Printed Name of patient's legal representative: _____ Relationship: _____

Witness: _____ _____
(Print Name) (Signature)

RENSSELAER COUNTY
DEPARTMENT OF MENTAL HEALTH

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RCDMH Consent for Telehealth Service Delivery

The Rensselaer County Department of Mental Health (RCDMH) is committed to providing services that are accessible to clients and their families. We recognize that, in certain circumstances, in-person face-to-face visits may not be the preferred or most optimal modality for therapy visits to occur. As an alternative, RCDMH is able to offer Telehealth visits via a secure HIPAA-compliant platform (Zoom for Healthcare). All persons receiving services must be afforded the opportunity to provide informed consent to participate in any services utilizing Telehealth Services.

This informed consent includes the following:

1) Telehealth is defined as the use of two-way real-time interactive audio and video equipment to provide and support mental health services at a distance. Audio-only treatment services are available on a very limited basis with appropriate supporting documentation. Telehealth services do not include a telephone conversation, electronic mail message, or facsimile transmission between a provider and a recipient, or a consultation between two professionals or clinical staff.

2) Clients have the right to refuse Telehealth Services.

3) Clients who decline treatment via Telehealth will need to travel to an authorized Clinic location to receive in-person services. Every effort will be made to provide clients with a timely in-person appointment.

4) Clients who wish to verify a Telehealth Practitioner's professional license may do so by visiting the NYSED Office of the Professions website: http://www.op.nysed.gov/opsearches.htm

5) Telehealth sessions will not be recorded.

6) Clients receiving Telehealth services will be billed in accordance with the rates and fees established by their insurance provider. This may require the payment of a co-pay or deductible.

Clients receiving Telehealth services have the following rights:

1) Clients have the right to be made aware of the role and license information of the Telemental Health Practitioner at the distant/hub site, as well as qualified mental health professional staff at the originating/spoke site who are responsible for follow-up or on-going care (if applicable).

2) Clients have the right to be made aware of the location of the practitioner's site and to have all questions regarding the equipment, the technology, etc addressed. The home addresses of practitioners who are operating remotely from an approved site will not be disclosed.

3) Clients have the right to have appropriately trained staff immediately available to him/her while receiving the Telehealth Service to attend to emergencies or other needs.

4) Clients have the right to be informed of all parties who will be present at each end of the Telehealth transmission.

5) If the recipient is a minor, the recipient and his or her parent or guardian shall be given the opportunity to provide input regarding who will be in the room with the recipient when Telehealth services are provided.

6) Clients receiving Telehealth services have the same right to confidentiality as required by Mental Hygiene Law Section 33.13 and 45 CFR Parts 160 and 164 (HIPAA Security Rules). This right to confidentiality includes, but is not limited to, written clinical/medical records, the actual transmission of the service, and any other electronic records, as well as the spaces occupied by the recipient at the originating/spoke site and the practitioner at the distant/hub site.

7) All Telehealth services will be performed on dedicated secure transmission linkages, and will employ acceptable authentication and identification procedures by both the sender and the receiver.

By signing below, clients are acknowledging that they have received notice of informed consent and recipient rights, and that they are voluntarily agreeing to receive services via Telehealth, as deemed appropriate and as agreed upon between the client and the practitioner.

Name: _____ Signature: _____ Date: _____

For clients under the age of 18, the parent or guardian acknowledges that they are giving consent for the youth to receive services via Telehealth, as noted above.

Client Name: _____ Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Client ID: _____
Date Completed: _____

RENSSELAER COUNTY
DEPARTMENT OF MENTAL HEALTH

Client Health Screening Form

Client's Legal Name: _____ Date of Birth: _____

Client's Preferred Name (if different than above): _____

Primary Insurance: Type of Insurance _____ ID Number _____

Secondary Insurance: Type of Insurance _____ ID Number _____

Pharmacy Benefit (ie Part D): _____ ID Number _____

Client's sex (as listed on current insurance card): Male ☐ Female ☐

Client's gender: Male ☐ Female ☐ Transgender (FTM) ☐ Transgender (MTF) ☐
Non-binary ☐ Other ☐ _____ Choose not to disclose ☐

Client's race (please choose one):
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black/African-American
- ☐ Other _____
- ☐ Pacific Islander/Hawaiian
- ☐ White/Caucasian

Client's ethnicity (please choose one):
- ☐ Not of Hispanic Origin
- ☐ Hispanic Origin
- ☐ Cuban
- ☐ Mexican/Mexican-American
- ☐ Other _____
- ☐ Puerto Rican

Primary Home Address: _____

Preferred Phone Number: (___) _____ Mobile ☐ Home ☐ Work ☐

Primary Email address: _____

Emergency Contact Name: _____

Address (if different from client): _____

Relationship to Client: _____

Preferred Phone Number: (___) _____ Mobile ☐ Home ☐ Work ☐

Email address: _____

Additional Contact Name: _____

Address (if different from client): _____

Relationship to Client: _____

Preferred Phone Number: (___) _____ Mobile ☐ Home ☐ Work ☐

Email address: _____

Client ID: _____

Client's preferred language: _____

Does client have prior or current active US military service? Yes ☐ No ☐

What best describes the client's religious preference (please choose one):

☐ I belong to a formal religious group (Please specify which group): _____
☐ I consider myself spiritual, but not religious
☐ I do not have a formal religion, nor am I a spiritual person
☐ Decline to answer

What best describes the client's employment status (please choose one):

☐ Employed (Please specify how many hours per week)
☐ Non-paid/volunteer work
☐ Unemployed, looking for work
☐ Not looking for work (ie – retired, student, disabled, etc).

Does the client receive any cash assistance benefits (select all that apply):

☐ SSI
☐ SSDI
☐ Veteran's disability benefits
☐ Veteran's case assistance
☐ Public assistance cash program (TANF, Safety Net, etc)
☐ Other cash benefits (pension, SSA retirement)

MEDICAL HISTORY

Primary Care Doctor: _____ Date of Last Exam: _____

Current medical issues/conditions: _____

Please list previous hospitalizations/surgeries/serious illnesses:

_____

_____

_____

Medical Difficulties experienced (Please indicate if **current** or **past** difficulty):

Current	Past		Current	Past	
☐	☐	Frequent headaches	☐	☐	Incontinence (Day or night wetting or pooping)
☐	☐	Asthma	☐	☐	Eye blinking
☐	☐	Frequent stomach aches	☐	☐	Nail biting
☐	☐	Serious Illness	☐	☐	Diabetes
☐	☐	Loss of consciousness	☐	☐	Arthritis
☐	☐	Poor physical growth	☐	☐	Allergies
☐	☐	Ear infections	☐	☐	High fevers
☐	☐	Seizures	☐	☐	Head injury

Client ID: _____

If you answered yes to any of the above, please describe follow up care:

_____

Has the client had problems with: ☐ Hearing ☐ Vision ☐ Speech

Has the client had problems with: ☐ Appetite Describe: _____

Has the client had problems with: ☐ Sleep Describe: _____

Has client received a flu shot this season? Yes ☐ No ☐

Has client ever had a COVID-19 virus test? Yes ☐ No ☐

Has client ever had a POSTIVE COVID-19 virus test? Yes ☐ No ☐

Has client had COVID-19 illness/symptoms? Yes ☐ No ☐

Has client been hospitalized for COVID-19 illness? Yes ☐ No ☐

Has client received COVID-19 vaccination? Yes ☐ No ☐

If yes, check all that apply: 1st shot ☐ 2nd shot ☐ Booster ☐

FAMILY HISTORY

Please list any serious or chronic physical illnesses suffered by the client's parents, siblings, or extended family:

_____

_____

_____

Is any close relative (parent, grandparent, sibling) diagnosed or treated for a mental health problem? Please give diagnosis and explanation:

_____

_____

_____

Please list other providers that work with you (ie – care manager, etc). You may use the back of the form if necessary: _____

Please ensure releases are on file and names have been added to the Health Care Team

Reviewed by clinician/prescriber: ☐ Staff name: _____ Date: _____

Client ID: _____

Better Health
for Northeast New York
A Partnership for Better Health

Alliance
FOR BETTER HEALTH

Welcome. This screening tool is used to support you with your health goals. There are no wrong answers. Your responses are completely confidential and do not affect your benefits and services.

Note: The screening tool should not be completed if you filled one out in the last 3 months.

In the last 12 months, did you ever eat less than you wanted because there wasn't enough **money for food**?	Yes ☐	No ☐
In the last 12 months, has your utility company shut off your service for not **paying your bills**?	Yes ☐	No ☐
Are you worried that in the next 2 months, you may not have **stable housing**?	Yes ☐	No ☐
Do problems getting **child care** make it difficult for you to work or study? (Leave blank if you do not have children)	Yes ☐	No ☐
In the last 12 months, have you needed to see a **doctor**, but could not because of **cost**?	Yes ☐	No ☐
In the last 12 months, have you ever had to go without healthcare, because you didn't have **a way to get there**?	Yes ☐	No ☐
Do you ever need **help reading** hospital materials?	Yes ☐	No ☐
Are you afraid you **might be hurt** in your apartment building or house?	Yes ☐	No ☐
If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Yes ☐	No ☐
Are any of your needs urgent? (For example: I don't have food tonight, I don't have a place to sleep tonight)	Yes ☐	No ☐

I give consent for the Rensselaer County Department of Mental Health to make a referral through the Healthy Together Network to address the needs that I have identified above.

Client Signature: _____

Date: _____

Client ID: _____

****

To be completed by CLIENTS age 12 and over ONLY
(PARENTS -- please allow YOUTH to answer questions)

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	0 ☐	1 ☐	2 ☐	3 ☐
Feeling down, depressed, or hopeless?	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling or staying asleep, or sleeping too much?	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired or having little energy?	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite or overeating?	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on things, such as reading the newspaper or watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual?	0 ☐	1 ☐	2 ☐	3 ☐
Thoughts that you would be better off dead, or of hurting yourself in some way?	0 ☐	1 ☐	2 ☐	3 ☐

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

☐ Not at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life? Yes ☐ No ☐

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or make a suicide attempt?
Yes ☐ No ☐

NOTE: Please remember to indicate on progress note for this session that Depression Screening was completed

Client ID: _____

****

Client Name: _____ Date of Assessment: _____

Alcohol

Do you drink alcohol? Yes ☐ No ☐

How often? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

How many drinks consumed? _____

(Men) Do you sometimes have more than 4 drinks in a day or more than 14 drinks in a week?
Yes ☐ No ☐

(Women/Seniors) Do you sometimes have more than 3 drinks in a day or more than 7 drinks in a week? Yes ☐ No ☐

(Pregnant woman) Do you consume any drinks? Yes ☐ No ☐

(Young adults) Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? Yes ☐ No ☐

Drugs

Have you used any illegal or street drugs? Yes ☐ No ☐

Drugs used: Cocaine ☐ Amphetamines ☐ Marijuana ☐ LSD/PCP/Ecstasy ☐
Inhalants ☐ IV Drugs ☐ Other _____

How often? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

How many uses? _____

Medication

Have you used medication other than as prescribed (more, for other reasons, someone else's, etc)
Yes ☐ No ☐

How often? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

How many uses? _____

Additional Comments

_____

_____

_____

Client ID: [ ]

****

To be completed by CLIENTS age 12 and over ONLY
(PARENTS -- please allow YOUTH to answer questions)

Have you ever taken any of the following drugs?

Heroin	Yes ☐	No ☐
Methadone	Yes ☐	No ☐
Buprenorphine	Yes ☐	No ☐
Morphine	Yes ☐	No ☐
MS Contin	Yes ☐	No ☐
Oxycontin	Yes ☐	No ☐
Oxycodone	Yes ☐	No ☐
Other opioid pain reliever (eg Fentanyl, Vicodin, Darvocet, etc) even if prescribed	Yes ☐	No ☐

NOTE: If client answers "Yes" to any question above, please complete the full RODS screening questionnaire

Tobacco Screening

Are there any concerns that client is? (check all that apply):

☐ Smoking cigarettes ☐ Using e-cigarettes/vaping ☐ Using drugs ☐ Drinking alcohol

Is the client a current tobacco user or smoker? ☐ Yes (smoker) ☐ Yes (smokeless) ☐ No

If yes to the above question, is client interested in quitting? ☐ Yes ☐ No

Does anyone in the household smoke cigarettes/use tobacco? ☐ Yes ☐ No

NOTE: Please remember to indicate on progress note for this session that Tobacco Screening was completed

Has the client received medication or a prescription for smoking cessation from this program in the past year? Yes ☐ No ☐

Has the client received counseling for smoking cessation from this program in the past year?
Yes ☐ No ☐

Client ID: _____

Other substance abuse screening questions

In the past 12 months, has the client received any treatment, counseling, or medication for any of the following?

Alcohol Use	Yes	☐	No	☐
Opiate-related Use	Yes	☐	No	☐
Any other substance	Yes	☐	No	☐