Organization Name: CNGCS	**Program Name:** ICRS	**Date:**
Individual's Name: (First, MI, Last)	**Record #:**	**Date of Birth:**

*OMH 2015 Patient Characteristics Survey (PCS) Reporting Element

Contact Information

Primary Telephone Number:		☐ OK to leave message
Secondary Telephone Number:		☐ OK to leave message
Living Address: Street/Avenue:	___ OK to ID	Apartment Number:
City/Town:	Zip Code:	County of Residence:
Mailing Address: Street/Avenue:	___ OK to ID	Apartment Number:
City/Town:	Zip Code:	

Communication
***Preferred language**

☐ English	☐ Portuguese/Creole	☐ Other Indo-European
☐ Spanish/Spanish Creole	☐ Italian	☐ African Languages
☐ Russian	☐ Polish	☐ Tagalog
☐ Mandarin	☐ Yiddish	☐ Korean
☐ Cantonese	☐ Hebrew	☐ Vietnamese
☐ Fujianese	☐ Arabic	☐ Other Asian
☐ Other Chinese	☐ Hindi	☐ Sign Language
☐ French	☐ Urdu	☐ Unknown
☐ French/Haitian Creole	☐ Other Indic (e.g., Sindhi)	☐ Other

SSN#

☐ Need for Translator / Interpreter: Sign Language / Language Interpreter: _____

☐ Need for Assistive Communication Device:

Literacy Needs: **Legally Identified Gender: Male Female**

Referral Source and Reason for Referral:

***Type of Health Insurance Coverage / Payment Source**

☐ **Child Health Plus**	
☐ **Medicaid - Managed Care**	
☐ **Medicaid**	
☐ **Medicare**	
☐ **Other**	
☐ **Private Insurance**	
☐ **Self-pay**	

CN guidance & counseling services
950 South Oyster Bay Road, Hicksville, New York 11801-3511 • Tel: 516 822-6111 • Fax: 516 396-0553 • www.centralnassau.org

Date: _____

Dear Client:

At CN Guidance and Counseling Services, We are committed to providing you with quality clinical services. Our Agency's policy requires your involvement with seeing a primary therapist for individual verbal therapy along with seeing a prescriber for medication management. Attendance at both of these **scheduled** sessions by you is of utmost importance and your responsibility to maintain.

If you have difficulty with keeping your individual verbal therapy session with your primary, you must discuss this with them ***immediately.*** If you do not and continue to miss your sessions, you may be in jeopardy of having your appointment with your prescriber to renew your medication cancelled.

Sincerely,

_____
Client Signature

_____
Therapist Signature

A

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

OMH Health Screen
NYSCRI v3.0.1, 03-2016

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Part A
Medical History and Current Physical Health Status

Doctor's Name:	Address:	Phone:	Date of Last Exam:
Dentist's Name:	Address:	Phone:	Date of Last Visit:
Specialist(s)' Name:	Address:	Phone:	Date of Last Visit:

Health Condition	Check if Yes	Managed by health care practitioner?
Blood condition: iron deficiency, sickle-cell anemia or trait	☐	☐
Cancer	☐	☐
Circulatory system: High Blood Pressure, Low Blood pressure, history of heart attack, heart disease, irregular heart beat	☐	☐
Dental Complaints	☐	☐
Digestive system: Liver problems, acid reflux, constipation, diarrhea, nausea, hepatitis, irritable bowel syndrome	☐	☐
Endocrine/Metabolic system: Thyroid disorder, diabetes, blood sugar issues, high triglycerides, high cholesterol	☐	☐

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

OMH Health Screen
NYSCRI v3.0.1, 03-2016

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Nutrition: Anorexia, Bulimia, loss or lack of appetite, overweight	☐	☐
Infectious disease: Tuberculosis, HIV/AIDS, sexually transmitted disease, Lyme	☐	☐
Reproductive / Urinary system: genital concerns, urinary tract infection, urinary and/or bowel incontinence	☐	☐
- Head - Eyes (wear glasses, blurred vision, blindness, pain, discharge) - Ears (Meniere's disease - dizziness, ringing, hearing loss) - Nose (bleeding) - Throat	☐	☐
Injuries: burns, complications of surgical and medical care, other physical injuries	☐	☐
Musculoskeletal system: back pain, bone loss, joint pain, Rheumatoid Arthritis, Gout, Lupus, Autoimmune disease	☐	☐
Nervous system: Alzheimer's, Epilepsy, Cerebral palsy, Multiple Sclerosis, Migraine, headache, sleep concerns, Parkinson's, stroke, movement disorder, brain disorder/injury	☐	☐
Respiratory system: Asthma, chronic pulmonary disease (COPD), coughing, emphysema, shortness of breath, trouble breathing while sleeping	☐	☐
Skin: infections, eczema, rash	☐	☐
Personal History of other diseases and conditions / symptoms: speech, fatigue, other	☐	☐

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

OMH Health Screen
NYSCRI v3.0.1, 03-2016

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Current Medication List

Medication	Dosage/Route/ Frequency	Purpose	Start Date or Length of Time Taken	Helpful ?	Prescriber
				○ No ○ Yes	
				○ No ○ Yes	
				○ No ○ Yes	
				○ No ○ Yes	
				○ No ○ Yes	

Click to Add Additional Medications

Past Psychiatric / Substance Use Disorder Medication

Medication	Dosage	Purpose	Start Date or Length of Time Taken	Reason for Stopping	Prescriber

Click to Add Additional Medications

Allergies / Drug Sensitivities

○ No ○ Yes If yes, complete information below

Severe or Anaphylactic Food Allergy:

Medicine:

☐ Latex / ☐ Other (specify):

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

OMH Health Screen
NYSCRI v3.0.1, 03-2016

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Medical hospitalization / Surgery

○No ○Yes If yes, complete information below

Date	Reason

Click to Add Additional Hospitalizations / Surgeries

Additional / Comment:

Nutrition

☐ 1. Any weight loss or gain of 10 pounds or more in the past three months

☐ 2. Change in appetite

☐ 3. Any other problems eating or drinking

Comment:

Pain

Any ongoing pain? ○No ○Yes If yes, Medical Staff completes pain section below.

For Women Only

Pregnant?

○No ○Yes If yes, expected delivery date:

If Yes, receiving pre-natal health care?

○No ○Yes If yes, indicate provider:

Menstrual Irregularities:

○No ○Yes Describe:

Postmenopausal:

○No ○Yes Describe:

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Is there anything else you want us to know about your health, as well as your beliefs and preferences about your health care (for example, needs around special foods, beliefs about taking medicine)?

○No ○Yes If yes, comment:

Completed By:	Signature:	Date:

Part B.
Medical Review (By physician, Nurse practitioner in Psychiatry, Physician's Assistant, or Registered Professional Nurse)

Vital Signs / Physical Health Indicators ☐ Did not measure Vitals

Blood Pressure:	Abdominal girth:	Temperature:	Pulse:
Respiration:	Height:	Weight:	BMI:
			Children: Also, percentile

Nutrition Status

Does individual have any nutrition related medical concerns that may interfere with treatment or for which s/he needs assistance? ○No ○Yes

If yes, explain:

Pain Assessment

Individual reported pain problems: ○No ○Yes If yes, complete:

Site #1	Site #2
Location:	Location:
Description:	Description:

Pain is adequately managed: ○No ○Yes

If no, is individual under medical care: ○No ○Yes - *If no, make referral and document below:*

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

OMH Health Screen
NYSCRI v3.0.1, 03-2016

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Recommended health services or referrals	
☐ Nutrition/Hydration	
☐ Pain	
☐ Other Specialty Care / Service	
☐ Primary Care Physician (General Referral)	
☐ Primary Care Physician for Physical Exam and Date, if known	

Clinical Summary of Findings

Health Information Reviewed by: Staff Name/Title/Credentials:	Signature:	Date:

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow CN Guidance and Counseling Services to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for CN Guidance and Counseling Services to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for CN Guidance and Counseling Services to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Healthix

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. 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 include 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

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **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 CN Guidance and Counseling services at: (516) 822-6111; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

guidance & counseling services
950 South Oyster Bay Road, Hicksville, New York 11801-3511 • Tel: 516 822-6111 • Fax: 516 396-0553 • www.centralnassau.org

Coordination of Care

Date: ____/____/____

_____

_____

_____

RE: Patient:
DOB:

Dear Dr. _____:

Your patient is being treated at the above address in our clinic for _____ disorder. To assist in coordination of care please send us

_____ Copies of all recent lab work
_____ All current diagnosis
_____ Medication List
_____ Other _____

A consent to release information is attached. We look forward to working with you for the benefit of our mutual patient.
Thank you.
ASMA A. EJAZ, MD
MEDICAL DIRECTOR

/ms

BBB MEMBER

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

*You must complete all required fields. We will not honor your request unless all required fields are completed. (*signifies a required field).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
CN Guidance & Counseling Services	950 SOBR Hicksville, NY 11801

***I want this information released because:**

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☒ Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC. AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.) (Please Print): _____ DOB: _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DESCRIPTION OF INFORMATION TO BE DISCLOSED (Check only those that apply)

Check one:

X Entire Medical Record
___ Medical Record (date) _____ to (date) _____
___ Other (Specify) _____

Patient/Client Initials next to each category of information that will be included:

_____ Substance Use Disorder Treatment Information (this will include all substance use disorder treatment information including diagnostic information, lab tests, medications, clinical notes, discharge summary, history and encounter data, unless specified below).

Description of any limitations on the type of substance use disorder treatment information to be disclosed (for example, "only my discharge summary"): _____

_____ Mental Health Information

_____ HIV/AIDS Information

Purpose or Need for Release of Information: This information is being requested: (Check all that apply)

☒ At the request of the patient (legal representative or guardian)
☐ Other (explain) _____

FROM/TO: Central Nassau Guidance & Counseling Services, Inc. **950 South Oyster Bay Road** **Hicksville, NY 11801** **Staff Name:** _____ **Phone: 516-822-6111** **Fax:** _____	**TO/FROM: Primary Care Physician** **(Include address)** _____ _____ **Attn:** _____ **Phone:** _____ **Fax:** _____

I understand that:

1. Only the information checked above may be used or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be re-disclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being re-disclosed by anyone who receives it unless the re-disclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time by contacting a CN Guidance staff person verbally or in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.
7. If my record contains alcohol and/or substance use disorder information, then any disclosure is bound by Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and substance use disorder patient records and re-disclosure of this information to any person or entity other than as designated above is _ without additional written authorization on my part.

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC.	Patient Name (Last, First, M.I.) (Please Print)

DISCLOSURE: I hereby authorize the release of the information described on page 1 of this authorization to the Person/Organization/Program identified to fulfill the purpose(s) indicated as follows:

☐ This authorization will terminate upon discharge.

☒ This authorization will terminate as of 90 days after discharge.

☐ This authorization will terminate as of: _____.

Patient Signature: I hereby authorize the use and disclosure of my health information as set forth in this document and understand that I am entitled to a copy of this signed authorization upon request.

_____ _____
Signature of Patient/Client Date

_____
Patient/Client's Name (Print)

_____ _____
Personal Representative's Signature Date

_____
Personal Representative's Name (Print)

_____
Description of Personal Representative's Authority to Act for the Patient (Required if Personal Representative signs)

WITNESS: I have witnessed the execution of this authorization by the person whose signature appears above.

Staff Person's Name & Title: _____ Date: _____

***In the event that I would like to revoke this consent, I am aware that I can contact an Agency staff person and request revocation of the authorization verbally or in writing.**

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

For Staff Use Only:

Patient _____ contacted CN Guidance on _____ to revoke this authorization.
Name of Patient Date of revocation

_____ _____
Signature of Staff Date

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC. AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.) (Please Print): _____ DOB: _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DESCRIPTION OF INFORMATION TO BE DISCLOSED (Check only those that apply)

Check one:

__X__ Entire Medical Record
__ Medical Record (date) _____ to (date) _____
__ Other (Specify) _____

Patient/Client Initials next to each category of information that will be included:

_____ Substance Use Disorder Treatment Information (this will include all substance use disorder treatment information including diagnostic information, lab tests, medications, clinical notes, discharge summary, history and encounter data, unless specified below).

Description of any limitations on the type of substance use disorder treatment information to be disclosed (for example, "only my discharge summary"):

_____

_____ Mental Health Information

_____ HIV/AIDS Information

Purpose or Need for Release of Information: This information is being requested: (Check all that apply)

☒ At the request of the patient (legal representative or guardian)
☐ Other (explain) **to provide information to Justice Center in case of incident**

FROM/TO: Central Nassau Guidance **& Counseling Services, Inc.** **950 South Oyster Bay Road** **Hicksville, NY 11801** **Staff Name:** _____ **Phone: 516-822-6111** **Fax:** _____	**TO/FROM: NYS JUSTICE CENTER** **(Include address)** _____ _____ **Attn:** _____ **Phone: 1-855-373-2122** **Fax:** _____

I understand that:

1. Only the information checked above may be used or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be re-disclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being re-disclosed by anyone who receives it unless the re-disclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time by contacting a CN Guidance staff person verbally or in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.
7. If my record contains alcohol and/or substance use disorder information, then any disclosure is bound by Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and substance use disorder patient records and re-disclosure of this information to any person or entity other than as designated above is _ without additional written authorization on my part.

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC.	Patient Name (Last, First, M.I.) (Please Print)

DISCLOSURE: I hereby authorize the release of the information described on page 1 of this authorization to the Person/Organization/Program identified to fulfill the purpose(s) indicated as follows:

☐ This authorization will terminate upon discharge.

☒ This authorization will terminate as of 90 days after discharge.

☐ This authorization will terminate as of: _____.

Patient Signature: I hereby authorize the use and disclosure of my health information as set forth in this document and understand that I am entitled to a copy of this signed authorization upon request.

_____ _____
Signature of Patient/Client Date

_____
Patient/Client's Name (Print)

_____ _____
Personal Representative's Signature Date

_____
Personal Representative's Name (Print)

_____
Description of Personal Representative's Authority to Act for the Patient (Required if Personal Representative signs)

WITNESS: I have witnessed the execution of this authorization by the person whose signature appears above.

Staff Person's Name & Title: _____ Date: _____

***In the event that I would like to revoke this consent, I am aware that I can contact an Agency staff person and request revocation of the authorization verbally or in writing.**

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

For Staff Use Only:

Patient _____ contacted CN Guidance on _____ to revoke this authorization.
Name of Patient Date of revocation

_____ _____
Signature of Staff Date

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC. AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.) (Please Print): _____ DOB: _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DESCRIPTION OF INFORMATION TO BE DISCLOSED (Check only those that apply)

Check one:

X Entire Medical Record
__ Medical Record (date) _____ to (date) _____
__ Other (Specify) _____

Patient/Client Initials next to each category of information that will be included:

_____ Substance Use Disorder Treatment Information (this will include all substance use disorder treatment information including diagnostic information, lab tests, medications, clinical notes, discharge summary, history and encounter data, unless specified below).

Description of any limitations on the type of substance use disorder treatment information to be disclosed (for example, "only my discharge summary"):

_____

_____ Mental Health Information

_____ HIV/AIDS Information

Purpose or Need for Release of Information: This information is being requested: (Check all that apply)

☐ At the request of the patient (legal representative or guardian)
☐ Other (explain)

FROM/TO: Central Nassau Guidance & Counseling Services, Inc. 950 South Oyster Bay Road Hicksville, NY 11801 Staff Name: _____ Phone: 516-822-6111 Fax: _____	TO/FROM: DEPARTMENT OF SOCIAL SERVICES (Include address) 60 Charles Lindberg Boulevard Uniondale, NY 11553 Attn: _____ Phone: 516-227-8519 Fax:

I understand that:

1. Only the information checked above may be used or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be re-disclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being re-disclosed by anyone who receives it unless the re-disclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time by contacting a CN Guidance staff person verbally or in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.

7. If my record contains alcohol and/or substance use disorder information, then any disclosure is bound by Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and substance use disorder patient records and re-disclosure of this information to any person or entity other than as designated above is – without additional written authorization on my part.

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC.	Patient Name (Last, First, M.I.) (Please Print)

DISCLOSURE: I hereby authorize the release of the information described on page 1 of this authorization to the Person/Organization/Program identified to fulfill the purpose(s) indicated as follows:

☐ This authorization will terminate upon discharge.

☒ This authorization will terminate as of 90 days after discharge.

☐ This authorization will terminate as of: _____.

Patient Signature: I hereby authorize the use and disclosure of my health information as set forth in this document and understand that I am entitled to a copy of this signed authorization upon request.

_____ _____
Signature of Patient/Client Date

_____
Patient/Client's Name (Print)

_____ _____
Personal Representative's Signature Date

_____
Personal Representative's Name (Print)

_____
Description of Personal Representative's Authority to Act for the Patient (Required if Personal Representative signs)

WITNESS: I have witnessed the execution of this authorization by the person whose signature appears above.

Staff Person's Name & Title: _____ Date: _____

***In the event that I would like to revoke this consent, I am aware that I can contact an Agency staff person and request revocation of the authorization verbally or in writing.**

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

For Staff Use Only:

Patient _____ contacted CN Guidance on _____ to revoke this authorization.
Name of Patient Date of revocation

_____ _____
Signature of Staff Date

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC. AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.) (Please Print): _____ DOB: _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DESCRIPTION OF INFORMATION TO BE DISCLOSED (Check only those that apply)

Check one:

☒ Entire Medical Record
__ Medical Record (date) _____ to (date) _____
__ Other (Specify) _____

Patient/Client Initials next to each category of information that will be included:

_____ Substance Use Disorder Treatment Information (this will include all substance use disorder treatment information including diagnostic information, lab tests, medications, clinical notes, discharge summary, history and encounter data, unless specified below).

Description of any limitations on the type of substance use disorder treatment information to be disclosed (for example, "only my discharge summary"):

_____

_____ Mental Health Information

_____ HIV/AIDS Information

Purpose or Need for Release of Information: This information is being requested: (Check all that apply)

☒ At the request of the patient (legal representative or guardian)
☐ Other (explain) **Drug Screen**

FROM/TO: Central Nassau Guidance & Counseling Services, Inc. **950 South Oyster Bay Road** **Hicksville, NY 11801** **Staff Name:** _____ **Phone: 516-822-6111** **Fax:** _____	**TO/FROM: QUALITY LABORATORY SERVICES** **(Include address) 1523 Voorhies Avenue** **Brooklyn, NY 11235** **Attn:** _____ **Phone: 718-646-5100** **Fax: 718-332-2574**

I understand that:

1. Only the information checked above may be used or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be re-disclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being re-disclosed by anyone who receives it unless the re-disclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time by contacting a CN Guidance staff person verbally or in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.

7. If my record contains alcohol and/or substance use disorder information, then any disclosure is bound by Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and substance use disorder patient records and re-disclosure of this information to any person or entity other than as designated above is _ without additional written authorization on my part.

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC.	Patient Name (Last, First, M.I.) (Please Print)

DISCLOSURE: I hereby authorize the release of the information described on page 1 of this authorization to the Person/Organization/Program identified to fulfill the purpose(s) indicated as follows:

☐ This authorization will terminate upon discharge.

☒ This authorization will terminate as of 90 days after discharge.

☐ This authorization will terminate as of: _____.

Patient Signature: I hereby authorize the use and disclosure of my health information as set forth in this document and understand that I am entitled to a copy of this signed authorization upon request.

_____ _____
Signature of Patient/Client Date

_____
Patient/Client's Name (Print)

_____ _____
Personal Representative's Signature Date

_____
Personal Representative's Name (Print)

_____
Description of Personal Representative's Authority to Act for the Patient (Required if Personal Representative signs)

WITNESS: I have witnessed the execution of this authorization by the person whose signature appears above.

Staff Person's Name & Title: _____ Date: _____

***In the event that I would like to revoke this consent, I am aware that I can contact an Agency staff person and request revocation of the authorization verbally or in writing.**

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

For Staff Use Only:

Patient _____ contacted CN Guidance on _____ to revoke this authorization.
Name of Patient Date of revocation

_____ _____
Signature of Staff Date

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CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC. AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.) (Please Print): _____ DOB: _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DESCRIPTION OF INFORMATION TO BE DISCLOSED (Check only those that apply)

Check one:

☒ Entire Medical Record
___Medical Record (date) _____ to (date) _____
___Other (Specify) _____

Patient/Client Initials next to each category of information that will be included:

_____ Substance Use Disorder Treatment Information (this will include all substance use disorder treatment information including diagnostic information, lab tests, medications, clinical notes, discharge summary, history and encounter data, unless specified below).

Description of any limitations on the type of substance use disorder treatment information to be disclosed (for example, "only my discharge summary"):

_____

_____ Mental Health Information

_____ HIV/AIDS Information

Purpose or Need for Release of Information: This information is being requested: (Check all that apply)

☒ At the request of the patient (legal representative or guardian)
☐ Other (explain) **Drug Screen**

FROM/TO: Central Nassau Guidance & Counseling Services, Inc. **950 South Oyster Bay Road** **Hicksville, NY 11801** **Staff Name:** _____ **Phone: 516-822-6111** **Fax:** _____	**TO/FROM:** **QUEST DIAGNOSTICS** **(Include address)** **157 Underhill Boulevard** **Syosset, NY 11791** **Attn:** _____ **Phone: 631-245-7629** **Fax: 610-271-8778**

I understand that:

1. Only the information checked above may be used or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be re-disclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being re-disclosed by anyone who receives it unless the re-disclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time by contacting a CN Guidance staff person verbally or in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.

7. If my record contains alcohol and/or substance use disorder information, then any disclosure is bound by Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and substance use disorder patient records and re-disclosure of this information to any person or entity other than as designated above is _ without additional written authorization on my part.

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC.	Patient Name (Last, First, M.I.) (Please Print)

DISCLOSURE: I hereby authorize the release of the information described on page 1 of this authorization to the Person/Organization/Program identified to fulfill the purpose(s) indicated as follows:

☐ This authorization will terminate upon discharge.

☒ This authorization will terminate as of 90 days after discharge.

☐ This authorization will terminate as of: _____.

Patient Signature: I hereby authorize the use and disclosure of my health information as set forth in this document and understand that I am entitled to a copy of this signed authorization upon request.

_____ _____
Signature of Patient/Client Date

_____
Patient/Client's Name (Print)

_____ _____
Personal Representative's Signature Date

_____
Personal Representative's Name (Print)

_____
Description of Personal Representative's Authority to Act for the Patient (Required if Personal Representative signs)

WITNESS: I have witnessed the execution of this authorization by the person whose signature appears above.

Staff Person's Name & Title: _____ Date: _____

***In the event that I would like to revoke this consent, I am aware that I can contact an Agency staff person and request revocation of the authorization verbally or in writing.**

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

For Staff Use Only:

Patient _____ contacted CN Guidance on _____ to revoke this authorization.
Name of Patient Date of revocation

_____ _____
Signature of Staff Date

REVIEW WITH CLIENT AND GIVE HANDOUTS TO CLIENT

CN guidance & counseling services

Hope starts here.

CN Guidance is one of 13 providers in New York, and the ONLY one on Long Island, who can now provide easy access to whole-person, integrated care through the Certified Community Behavioral Health Clinic project. We believe that everyone can recover, and are pleased to be able to offer

Enhanced CCBHC services:

Integrated Mental Health and Substance Use Treatment – Our team serves adults, adolescents, and children who are affected by mental health and/ or substance use disorders. We provide individual, group, and family therapy, psychiatric evaluation and medication management, plus same-day access to care. We provide Detox from and ongoing Medication-Assisted Treatment for opioids, alcohol, and benzodiazepines – in an outpatient setting.

Screening, Assessment & Diagnosis – Using tools and practices that have been proven effective, our clinical treatment team will help you determine what your needs are and how to best help you recover. We use a Patient-Centered Planning and Treatment Approach that puts your ideas and preferences for your care first.

Primary Medical Care – At our Wellness Center, we have doctors and staff onsite who can help you manage or reduce the risk of chronic illnesses like Heart Disease, Diabetes, Stroke, and COPD.

Targeted Case Management – A case manager can work with you and your staff to help you connect to additional resources at CN Guidance and in the community, manage all of your healthcare and benefits needs, and get additional supports during times of crisis.

Psychiatric Rehabilitation Services – Our specially trained staff can work with you at home, at the clinic, or in the community to help you restore your well-being and build skills in any area of your life.

Peer and Family Supports – Certified peer specialists (staff members who also receive services for mental health and substance use issues) provide support and counseling, and are available to help as you experience changes in your care or your life. Staff can visit you in the community if getting to the clinic is difficult for you.

Personalized Care for members of the Armed Forces – Anyone with current or prior military service (regardless of branch, service type or discharge status) or their families can receive services from staff who have been specially trained in recognizing and working with the unique circumstances of our nation's Veterans.

Crisis Intervention – Our dedicated staff can provide emergency crisis intervention & stabilization and crisis planning any time of day or night. Through our relationship with community partners, we have access to a mobile crisis team 24-hours a day, 7-days a week.

Talk with your staff today about our CCBHC services to help you decide what's best for you!

guidance & counseling services

STATEMENT OF CLIENTS' RIGHTS

Each client enrolled in the Integrated Counseling and Recovery Services program has the following rights:

1. To receive services that are responsive to individual needs in accordance with an individualized treatment plan, which the client helps develop and periodically update; that are protected by 45 CFR, and if applicable, 42 CFR. You have the right to a full explanation of the services provided in accordance with your treatment plan. Treatment or access may not be limited due to race, creed, color, sex, national origin, or handicap condition
2. To receive services from staff who are competent, respectful of client dignity, cultural environment and personal integrity; and in sufficient numbers to deliver needed services as per regulatory requirements.
3. To receive services in a therapeutic environment that is safe, sanitary, and free from the presence of alcohol or other drugs or abuse.
4. To know that name, position, and function of any person providing treatment and to be able to communicate with the program director, medical director, CPO, CEO, board of directors, other responsible staff, the NYS Office of Alcohol and Substance Abuse Services (OASAS) commissioner or the NYS Office of Mental Health (OMH) commissioner.
5. To receive information concerning treatment, such as diagnosis, condition, or prognosis in understandable terms, and to receive series requiring a medical order only after such order is executed by an appropriate medical professional.
6. To receive information about provider services available on site or through referral, and how to access such services;
7. To receive prompt and reasonable response to request for provider services, or a statue future time to receive such services in accordance with an individual treatment plan;
8. To know the standards that apply to client conduct, receive timely warnings for conduct that could lead to discharge, and receive incremental interventions for non-compliance with treatment plans;
9. To receive in writing the reasons of a recommendation of discharge and information on appeal procedures;
10. To voice a grievance, file a complaint, or recommend a change in procedure or service to provider staff and/ or OASAS and OMH, free from intimidation, reprisal, or threat;
11. To examine, obtain a receipt, and receive an explanation of provider bills, charges, and payments, regardless of payment sources;
12. To receive a copy of the client's records for r reasonable fee;
13. To be free from physical, verbal, or mental abuse, and to be treated by provider staff who are free from alcohol or drug abuse;
14. To be free from any staff or client coercion, undue influence, intimate relationships, and personal financial transactions;
15. To be re from performing labor or personal services solely for provider or staff benefit, that are not consistent with treatment goals, and to receive compensation for any labor or employment service in accord with applicable state and federal law.
16. Individuals referred to a faith-based provider may request a non faith-based provider;
17. Clients, unless otherwise court mandated, have the right to refuse treatment.

QUESTIONS OR CONCERNS, PELASE CONTACT OUR DIVISION DIRECTOR: MARY SILBERSTEIN, LCSW-CASAC(G): 516-822-6111

guidance & counseling services

COMPLAINT/GRIEVANCE PROCEDURE

The following procedure is to be followed in the event a client finds it necessary to register a complaint about the Program, its policies, procedures, services, or staff.

1. The client should discuss his/her complaint with any clinical staff member of the Clinic.
2. If the complaint cannot be satisfactorily resolved, the client should speak with the Coordinator or Division Director who will attempt to resolve the complaint. If within 3-5 business days a satisfactory resolution has not been achieved, the client will be advised to put the complaint in writing. At this time the complaint will be formally investigated.
3. The Division Director will notify the CPO and forward him/her a copy of the written complaint. If they are unable to resolve the complaint within 7-10 days, he/she will refer the matter to the Agency's Special Investigator for further review.
4. The Special Investigator will conduct a review within 30 days of receiving the complaint and send a written report to the Division Director with the findings and any recommendations or corrective action required.
5. The Division Director will review the recommendations and corrective action plan of the Special Investigator in consultation with the CPO and/or other administrative staff and implement the necessary changes as appropriate.
6. The Division Director will meet with the client to review the findings and recommendations of the Special Investigator and provide feedback about the complaint within 30 days of receiving the completed report.
7. Should the client still feel the complaint has not been satisfactorily resolved, he/she may appeal to the Compliance Officer and/or CPO for an additional review of the matter.
8. Once the review has been completed, the client will be notified in writing of the outcome.

All clients, at any time, may contact the following individuals to discuss their concerns:

Roseann Falcone, or LeeAnn Diedrick, Clinical Coordinators (516) 822-6111
Mary Silberstein, Division Director, (516) 822-6111
Nancy Manigat, CPO, (516) 822-6111
Jeffrey Friedman, CEO, (516) 822-6111
Ariel Coffman, Compliance Officer, (516) 822-6111
Arlene Gonzalez-Sanchez, NYS OASAS Commissioner, 518- 473-3460
Anne Marie T. Sullivan, NYS OMH Commissioner, 1-800-597-8481

CN guidance & counseling services

PROGRAM RULES AND REGULATIONS

1. Abstinence from the use of alcohol and drugs (except prescribed) is a goal in your treatment if you have a substance use disorder diagnosis.

2. Any client presenting as under the influence of alcohol and drugs will be assessed for risk, asked to leave, and may be faced a referral to detox or inpatient treatment. Random urine and oral swab testing is required in treatment. Refusal/non-compliance is viewed as a positive test. Urine/Oral Swab results are reported to mandated referral sources with no exceptions.

3. All medications must be prescribed by a prescriber. If your medication is not prescribed by a CN Guidance prescriber, you must:

    a. bring a copy of the prescription or medication bottle to your primary counselor to assure documentation in your records,
    b. sign a release of information consent to allow us to collaborate treatment with your physician.

4. Clients and staff are entitled to respect and consideration at all times. Any person showing disrespect: physical or verbal intimidation, vulgarity, or any inappropriate behavior to clients or staff in the program will be asked to leave and may face termination from treatment.

5. **Confidentiality must be adhered to at all times. Information shared within a group is not to be discussed with any person outside the group except for treating staff.** Group members should refrain from beginning or continuing dialogue from group sessions in the waiting room area, or outside building.

6. Participation in treatment is a commitment toward your recovery. Treatment plans are reviewed for progress and revision by your primary counselor with your active input and participation in the process. If you have a substance use disorder diagnosis, 12 step meetings or dual recovery meetings are encouraged and incorporated into your treatment plan goals. Staff will provide area meeting lists to all applicable clients.

6. Participation in group sessions will be designed by you and your therapist. Any problem areas need to be discussed and resolved with your therapist or doctor.

7. Mandated clients will have reports sent weekly and/or monthly to their mandating source (AOT, probation, parole, TASC, etc.) to allow compliance with stipulations. Clients are required to sign releases of information to allow staff to provide the necessary information. Any person refusing to sign the necessary releases of information, or giving false information regarding their legal status, may face termination from the Program.

8. **ANY PERSON ASSOCIATED OR INVOLVED DIRECTLY OR INDIRECTLY WITH THE SECURING, SOLICITING, PURCHASING, OR POSSESSION OF ANY ILLEGAL OR CONTROLLED SUBSTANCE ON THEIR PERSON, OR WITHIN THE AGENCY WILL BE AUTOMATICALLY DISCHARGED.** Your anonymity in reporting any incidents to staff is assured and will help all clients sincere in their recovery efforts.

9. **NO WEAPONS OF ANY KIND ARE TO BE BROUGHT INTO THIS AGENCY.** If a weapon is brought into this Agency (concealed or not concealed) the Police (911) will be called and you will be automatically discharged.

10. Your attendance is a critical component of your treatment. All therapy and prescriber sessions and groups begin **ON TIME**. Anyone who is excessively absent or habitually late for sessions may be in jeopardy to being discharged from the Program. Absences are rarely excused, except due to illness and/or emergency situations. You need to address any attendance problems with your primary therapy or group facilitator, as our attendance policy is strictly adhered to, and exceptions need to be reviewed and documented in a timely matter.

11. The Program utilizes a multi-disciplinary team approach and information is shared by various professional staff to assure that each client is afforded concise and effective treatment. Should you have any problem, or should you disagree with your recommended treatment, you should make an appointment to discuss the matter with your primary therapist. If you feel the issue has not been resolved, or you wish to dispute the treatment decision, a meeting can be arranged with the Coordinator(s) of ARTS or Counseling Center or the Program Director.

12. Fees for service are discussed at the time of your intake during your 'fee set' appointment. Any documentation or information requested during this process must be furnished to continue your admission process. Please see the 'fee set policy' included in this packet.

13. We reserve the right to alter or amend any program regulations which serve the best interest of our clients, and which solidify our Program confidentiality regulations, and assure the protection of all participants and staff.

Your intake therapist will be reviewing these regulations, and the other information included in this packet during the orientation phase of your treatment, and will be happy to answer any questions you may have at that time. It is our goal to assure that each person participating in treatment is fully informed regarding their rights as well as their responsibilities while in treatment at CN Guidance.

guidance & counseling services

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

For clients with substance use disorder diagnoses, Federal law confidentiality and regulations protect the confidentiality of alcohol and drug abuse client records maintained by this Program/Agency. Generally, the Program may not say to a person outside the Program/Agency that the client attends the Program, or disclose any information identifying a client as an alcohol or drug abuser unless:

1. No client-identifying information is provided; OR
2. The client consents in writing utilizing a proper consent form; OR
3. The disclosure is made to medical personnel in medical emergency or to qualified personnel for research, audit, or program evaluation; OR
4. The disclosure is allowed by a court order; OR
5. A qualified service organization/business associate agreement ("QSOA")* exists between the Program/Agency and other professional entities for the benefit of the Program's clients; OR
6. The client commits or threatens to commit a crime either at the Program or against any person who works for the Program.

Violation of federal confidentiality and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the District where the violation occurs.

Federal confidentiality and regulations do not protect any information about suicide, homicide, or suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

*Effective June 30, 2013, the NYS Protection of People with Special Needs Act mandates agencies such as Central Nassau Guidance & Counseling Services, Inc. to report **any significant incidents** such as abuse, neglect, death and so on to the NYS Justice Center. A QSOA between these two entities allows for such disclosure.

guidance & counseling services

STATEMENT REGARDING FEE POLICY

- Fees are needed to help utilize the funds which enable us to provide various services to our clients.

- Fees are set at the time of your first visit. At this time, you are required to present verification of your income by providing current proof of income (copy of 1040, pay stubs, unemployment checks, etc.). If you don't provide documentation then your fee will be set at the highest rate of our current fee scale.

- **Payment is required before the start of each visit. In order to be on time for your appointment, please arrive 15 minutes prior to scheduled visit to pay for session.**

- **The Agency reserves the right to suspend visits when the unpaid balance equals two session fees.**

- You will be charged for all appointments, including those you fail to keep with less than 24-hour notice. If your therapist or doctor has to cancel an appointment, you will not be charged.

- If there are any changes in the financial status upon which your sliding scale fee was set, then it should be discussed with your therapist.

- If you find that the fee determined at intake may prohibit your ability to participate in the program, or you acquire an outstanding balance on your account due to financial hardship, you must contact your therapist immediately for assistance and request a fee reduction review.

- Non-payment of fees is considered non-compliance with our program regulations and may result in discharge from the program with notification to appropriate mandated treatment referral sources (probation, parole, TASC, CPS, drug court, etc.) No treatment completions or reports will be issued until the outstanding account balance is paid in full.

- At this time most insurance companies, do not authorize multiple visits in the same day. If your insurance DOES NOT pay for multiple visits in the same day you will be charged a fee for the additional services.

- Copays and deductibles for Medicare and commercial insurances cannot be waived regardless of you financial situation.

PRIVATE HEALTH INSURANCE

You are required to use your private health insurance as a resource to pay for treatment. Your fee responsibility is your co-pay plus the insurance reimbursement, which will be assigned to CNGCS. You may also be responsible for any deductibles that apply. If for any reason your insurance company fails to pay, you will be responsible for any remaining balance.

- We are providers for certain managed care companies, for which the policies in this letter may not apply. If you have managed care mental health coverage, we will discuss with you policies specific to your coverage.

- CNGCS requires that you give us all information regarding any insurance that covers you. If you fail to provide us with any information regarding a change in insurance, then you will be responsible for the full fee for any services provided.

MEDICARE

Medicare requires that we charge you any portion of your deductible that has not been met along with the annually revised co-insurance fees. If you have any questions about these fees, please discuss them with your therapist.

- We require that you bring your Medicare Card with you.

- If you have opted to become part of a Medicare managed-care company, you must use one of those providers unless the insurance provides out of network coverage that we can access. Please check with us to see if we are a provider for your insurance.

MEDICAID

- For persons who have Medicaid, there is no co-payment. It is necessary for you to present your Medicaid card each time you come to the Center. If your Medicaid card is not active or ineligible, you will need to take immediate action to reactivate it. You will be charged standard agency fee until this situation is resolved.

- It is your responsibility to keep all scheduled appointments. Continued failure to keep your scheduled appointments may jeopardize your treatment.

- If you have Medicaid with a spenddown, you will need to arrange to pay that spenddown in order to activate your Medicaid. You will discuss this with your therapist. You have two options available in order to pay off your spenddown. You may pay the amount of the spenddown to the Dept. of Social Services each month, or for several months. You may submit medical bills to the Dept. of Social Services, which equal or exceed your spenddown. Either of these choices will allow you to use your Medicaid for other medical expenses.

***If you choose not to activate your Medicaid spenddown, a fee will be set for all sessions, which are attended.**

- If you have Medicaid Managed Care you must use one of your managed care company providers. In some instances, this may include Central Nassau. Please check with us.

guidance & counseling services

950 South Oyster Bay Road, Hicksville, New York 11801-3511 * Tel: 516-822-6111 * Fax: 516-396-0552 * centralnassau.org

DRUG TESTING FEE POLICY

The Office of Mental Health has indicated in their "Clinic Standards of Care" that all treatment providers screen for the presence of current use of alcohol or other substances. As a result, an oral or urine tox screen will be performed at intake/screening for all incoming Patients and randomly throughout their course of treatment. This procedure is used for assessment and diagnostic purposes.

Urine Toxicology Screens/Oral Swabs will be billed directly to your insurance company. Any co-pays or deductibles are your responsibility to pay directly to the Drug Lab utilized and are not the responsibility of this agency. If you do not have insurance benefits, you will be responsible to pay for a self-pay fee of $35.00 directly to the lab.

If you cannot afford $35.00 a screen or have a hardship due to the co-pays of your insurance deductible, please discuss this with your therapist or a case-by-case arrangement can be made with the Drug Labs utilized by the Agency.

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Medication & Controlled Substances Guidelines

I understand that in order to maximize my treatment at Central Nassau Guidance, I will adhere to the following guidelines:

- The Counseling Center judiciously prescribes benzodiazepines (Xanax, Klonopin, Ativan, and Valium) to help manage the symptoms of severe anxiety. These medications are indicated solely for this purpose and are monitored by the prescribing physician or another physician within this agency. It is against our policy to have an outside physician prescribe these medications without the knowledge and consent of your physician within the Counseling Center.

- Due to the I-STOP legislation, all prescribers will be checking the New York State Prescription Monitoring Program registry. This registry allows physicians to monitor the distribution of prescriptions of narcotics throughout the state to prevent the misuse or abuse of medications which are addictive. In the event any questionable behavior arises, your treatment providers will need to address such behaviors and may recommend modifying your treatment at the Counseling Center.

- Opioid analgesic medications (Vicodin, Oxycontin, Percocet, etc…) are to be prescribed by a single physician. Dosages should fall within the manufacturer's recommended guidelines.

- Consents to speak with all doctors involved in your treatment will be signed and those doctors will be made aware of this agreement that pain medication will only come from one source. Your therapist or psychiatrist (agency doctor) will have regular contact with the physician that is managing your pain, and that physician will be made aware of this contract.

- Psychotropic medications are to be taken as prescribed. Any changes must be made in consultation with my psychiatrist.

- Prescriptions for controlled substances will not be refilled before the anticipated end date. This includes any lost or stolen prescriptions. All prescriptions are done through our Electronic medical record system.

CN guidance & counseling services
950 South Oyster Bay Road, Hicksville, New York 11801-3511 • Tel: 516 822-6111 • Fax: 516 396-0553 • www.centralnassau.org

PRESCRIPTION FACT SHEET

- Please schedule your next medication management appointment prior to leaving today.
- Take all your medication as prescribed and do not share your medication with anyone else.
- Make sure that your Pharmacy has dispensed the correct amount and has logged in the refills on your prescription.
- When your prescription needs to be refilled, please look on the bottle and contact your Pharmacy first to see if they have any refills on hold before you call CN Guidance.
- Please plan your prescription needs ahead and don't wait until Friday, Saturday and Sunday to call for a prescription refill.
- Please alert your Prescriber of all new medications, medical problems/diagnoses or allergies so they can be added to your chart.
- Please inform your Prescriber when you change medical providers or add new ones.
- If you are receiving Benzodiazepines (Klonopin, Xanax, Valium, Ativan, etc.), you will not receive a medication renewal without a face to face visit with your Prescriber.
- If you are receiving Benzodiazepines, you must be seen by your Prescriber monthly for medication renewals.
- If you run out of your medication, you may only receive enough refill medication to see you through to your next scheduled prescriber appointment.

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Dear Client:

It is a pleasure to serve you during the course of your care at our Agency. We hope that we have demonstrated our genuine concern for your therapy.

This letter is to communicate our policy regarding keeping appointments. In the near future you will be receiving a confirmation call 2 business days prior to your scheduled appointment. If the time of your appointment is no longer convenient we will reschedule it to a time that works for you.

At any time if you need to change your appointment we ask that you call at least 48 hours in advance of the appointment:

- During office hours call 516-822-6111 EXT 1630
- After office hours call 516-822-6111 EXT 1630 and leave a message of cancellation and request a call back to reschedule an appointment.

We will consider your appointment status as a "No Show" if your appointment is cancelled less than 48 hours prior to the scheduled time or if you fail to show for a scheduled appointment. After a late cancellation, or no show of a scheduled appointment will be contacted by phone by the appointment desk to reschedule your appointment. After a second late cancellation, or no show of a scheduled appointment, you will be contacted by phone by our Reengagement Specialist to assist with developing ways to maintain good standing and improve compliance. If a call is not returned within 24 hours, a letter will be sent outlining the reason for the call including the current policy and a call back will be requested to address your services.

After two late cancels and or No Shows, you will be blocked from scheduling with your current clinicians and prescriber and may only receive crisis or walk in services (unless otherwise determined) and our Reengagement Specialist will contact you by phone and will recommend our Reengagement group.

We are also working with staff to reduce the possibility of their cancelling appointments with you (not giving you 24-hours notice prior to cancelling appointments). By asking both staff and our client to help in reducing the time lost in service delivery, we will be able to provide more services to those in need.

We are pleased to be able to partner with you in helping to reach your therapy It's always exciting to see our clients get the results they want. Please accept our warmest thanks and gratitude for allowing us to participate with you in the recovery of your health.

Sincerely,

Division of Integrated care & Behavioral Health Services

CENTRAL NASSAU
Guidance & Counseling Services, Inc.

On-Site Primary Care Services
At the
Wellness Center

These services include:

- Physical Exams
- Medical Screenings
- Vital Signs
- Depression Scales
- Referrals to Specialists
- Internal Wellness/Prevention Counseling
- Internal Follow-up Monitoring, Support and Assessments

To schedule an appointment today:

950 S. Oyster Bay RD
Hicksville, NY 11801
Call Kim Cronin at
516-822-6111 x-1330

The Lifeline is FREE, confidential, and always available.

HELP a loved one, a friend, or yourself.

Community crisis centers answer Lifeline calls.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Printed 2005 • Reprinted 2011
CMHS-SVP-0126

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK (8255)

suicidepreventionlifeline.org

Learn the Warning Signs.

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Suicide Is Preventable.

Call the Lifeline at 1-800-273-TALK (8255).

With Help Comes Hope

OASAS
Improving Lives.

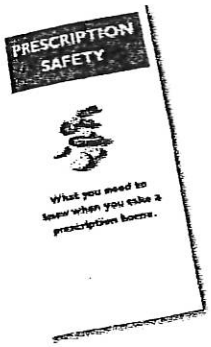
Protect Your Children
BE AWARE & DON'T SHARE

YOU SHOULD KNOW

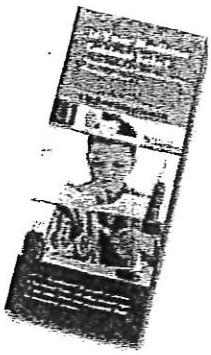
- 1 in 5 teens are abusing prescription drugs.
- 70% of prescription drugs are obtained from a friend or relative.
- 40% of teens believe prescription drugs are safer than illicit drugs.
- Prescription drugs can be addictive and lethal when misused.
- Combining prescription drugs/over the counter medications and alcohol can cause respiratory failure and death.
- After alcohol and marijuana, prescription drugs are the next most abused drugs among youth.

WHAT CAN YOU DO?

- Safeguard all prescription drugs and medications at home.
- Monitor the quantities on a regular basis to control access.
- Dispose of old or unused medications.
- Be a good role model; follow the same rules with your own use.
- Ask family and friends to safeguard their medications.
- Talk to your teen about alcohol and drug abuse and the risks of abusing prescription and over-the counter drugs.



Brochures are available to download, print and distribute
www.oasas.ny.gov/stoprxmisuse/
www.health.ny.gov/diseases/aids/harm_reduction/opioidprevention/index.htm
New York State HOPEline: **1-877-8-HOPENY** (1-877-846-7369)
Toll-Free, Anonymous and Confidential / 24 hours a day, 365 days a year



OASAS
Improving Lives.
NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

1450 Western Avenue • Albany, New York 12203-3526 • www.oasas.ny.gov • 518-473-3460

OPIOID OVERDOSE PREVENTION FACTS

Protect your Children
BE AWARE & DON'T SHARE

NYS Office of Alcoholism and Substance Abuse Services (OASAS)
New York State HOPEline: **1-877-8-HOPENY (1-877-846-7369)**
Anonymous, Confidential and Toll-Free
24 hours a day, 365 days a year

OPIOID OVERDOSE: [coma, decreased breathing rate and very small (pinpoint) pupils (the black center part of the eye)]

- is a preventable death in the majority of cases and
- can be treated (reversed) effectively with naloxone (Narcan).

WHAT DRUGS ARE OPIOIDS?

- Examples include: heroin; morphine; codeine; methadone; oxycodone (Oxycontin); hydrocodone (Vicodin); oxymorphone (Opana); and fentanyl (Duragesic).
- Naloxone does not reverse overdoses in which:
  - non-opioid sedating drugs (benzodiazepines), alcohol, ketamine or stimulants are used.

IDENTIFY RISK FACTORS:

- **Loss of tolerance**: Regular use of opioids leads to greater tolerance, i.e. more is needed to achieve the same effect (high). Overdoses occur when people start using again following a period of not using (abstinence) such as after coming out of treatment, detox or incarceration.
- **Mixing Drugs**: Mixing opioids with other drugs, especially depressants such as benzodiazepines (Xanax, Klonopin) or alcohol can lead to an overdose. The effect of mixing drugs is greater than the effect one would expect if taking the drugs separately.
- **Variation in strength of street drugs**: Street drugs may vary in strength and effect based on the purity.
- **Serious illness**: Users with serious illnesses such as HIV/AIDS, liver disease, diabetes and/or heart disease are at greater risk for overdose.
- **Drug use alone**: As no one is present to initiate rescue measures if an overdose occurs, this is particularly high risk.

RISK LEVEL/INTERVENTION:

- When high risk is assessed, **TAKE ACTION**:
  - to reduce risk of multiple potentiating medications, use only one prescriber;
  - educate all you know and love on overdose signs, risk and NARCAN use to prevent overdose;
  - educate all you know and love about signs of opioid overdose; and
  - consider getting a substance use disorder assessment from your healthcare provider or local substance use disorder treatment program if you believe addiction is a possible issue.

OASAS supports a broad range of philosophies and approaches to SUD treatment. Regardless of approach, the goal is to provide care that will engage and support patients throughout the process and stages of their recovery.

A new life-saving law took effect in 2006, making it legal in New York State for non-medical persons to administer naloxone to another individual to prevent an opioid/heroin overdose from becoming fatal. Any adult who has been trained and furnished with naloxone is able to act as an overdose responder. All OASAS programs with prescribers on staff (physicians, nurse practitioners and physician assistants) are encouraged to register as programs which can train staff and patients in the use of naloxone. OASAS also encourages staff at OASAS licensed programs without prescribers on staff to become trained as overdose responders so that they may be able to administer naloxone in the case of a suspected opioid overdose.

- www.oasas.ny.gov/stoprxmisuse/
- www.health.ny.gov/diseases/aids/harm_reduction/opioidprevention/index.htm

OASAS Improving Lives
New York State Office of Alcoholism & Substance Abuse Services
1450 Western Avenue ● Albany, New York 12203-3526 ● www.oasas.ny.gov ● 518-473-3460

CENTRAL NASSAU GUIDANCE & COUNSELING SERVICES, INC.
ADDICTION RECOVERY TREATMENT SERVICES

HIV/AIDS Basic Information

The staff of this Agency are concerned not only with your reason for coming to us for an assessment and/or treatment, but also with many other issues affecting our clients. One of our concerns is the medical condition known as HIV/AIDS.

- HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS. HIV can attack and destroy the immune system and the body's defense against germs, viruses, and bacteria.

- AIDS stands for Acquired Immune Deficiency Syndrome. It is the name given to the collection of infections HIV positive people are susceptible to.

- HIV is passed from one person to another through certain bodily fluids; blood, semen, vaginal fluids, breast milk, and menstrual flow.

- HIV is **not** through saliva, urine, feces, sweat, or tears (unless there is blood in the fluid).

- You can be infected by:
  - Unsafe sex (not using a latex condom) of any kind, including oral, vaginal or anal sex.
  - Sharing I.V. drug paraphernalia such as a syringe, cotton, or cooker.
  - Infected mothers can transmit the virus to babies through pregnancy, birth and breast feeding.

If you have placed yourself at risk, you may want to be tested for HIV. You may be tested by your doctor, a clinic, or you can call the Department of Health at:

Nassau:	**(516) 535-2004**
Suffolk:	**(631) 853-2999**
NY State Hotline:	**1-800-872-2777**

Our treatment program will cover other aspects of HIV and AIDS. Please do not hesitate to ask your counselor any questions you may have regarding this serious illness.

New York State Department of Health

Tuberculosis (TB)

Last Reviewed: June 2007

What is tuberculosis?

Tuberculosis is a bacterial disease usually affecting the lungs (pulmonary TB). Other parts of the body can also be affected, for example lymph nodes, kidneys, bones, joints, etc. (extrapulmonary TB). Approximately 1,300 cases are reported each year in New York State.

Who gets tuberculosis?

Tuberculosis can affect anyone of any age. People with weakened immune systems are at increased risk.

How is tuberculosis spread?

Tuberculosis is spread through the air when a person with untreated pulmonary TB coughs or sneezes. Prolonged exposure to a person with untreated TB usually is necessary for infection to occur.

What is the difference between latent tuberculosis infection and tuberculosis disease?

Latent tuberculosis infection (LTBI) means the person has the TB germ in their body (usually lungs), but has yet to develop obvious symptoms. In latent TB, the person has a significant reaction to the Mantoux skin test with no symptoms of tuberculosis, and no TB organisms found in the sputum. Tuberculosis disease indicates the person has symptoms, a significant reaction to a Mantoux skin test and organisms found in the sputum. In order to spread the TB germs, a person must have TB disease. Having latent TB infection is not enough to spread the germ. Tuberculosis may last for a lifetime as an infection, never developing into disease.

What are the symptoms of tuberculosis?

The symptoms of TB include a low-grade fever, night sweats, fatigue, weight loss and a persistent cough. Some people may not have obvious symptoms.

How soon do symptoms appear?

Most people infected with the germ that causes TB never develop active TB. If active TB does develop, it can occur two to three months after infection or years later. The risk of active disease lessens as time passes.

When and for how long is a person able to spread tuberculosis?

A person with TB disease may remain contagious until he/she has been on appropriate treatment for several weeks. However, a person with latent TB infection, but not disease, cannot spread the infection to others, since there are no TB germs in the sputum.

What is the treatment for tuberculosis?

People with latent TB infection should be evaluated for a course of preventive therapy, which usually includes taking antituberculosis medication for several months. People with active TB disease must complete a course of treatment for six months or more. Initial treatment includes at least four anti-TB drugs, and medications may be altered based on laboratory test results. The exact medication plan must be determined by a physician. Directly observed therapy (DOT) programs are recommended for all TB patients to help them complete their therapy.

What can be the effect of not being treated for tuberculosis?

In addition to spreading the disease to others, an untreated person may become severely ill or die.

What can be done to prevent the spread of tuberculosis?

The most important way to stop the spread of tuberculosis is for TB patients to cover the mouth and nose when coughing, and to take all the TB medicine exactly as prescribed by the physician.

What is multidrug-resistant tuberculosis (MDR-TB)?

This refers to the ability of some strains of TB to grow and multiply even in the presence of certain drugs which would normally kill them.

What is extensively drug-resistant tuberculosis (XDR-TB)?

Extensively drug-resistant TB (XDR-TB) is a subset of MDR-TB in which the strains of TB bacteria are resistant to several of the best second-line drugs for TB. These strains are very difficult to treat. XDR-TB cases make up approximately 10 percent of MDR-TB cases.

Who gets MDR-TB?

TB patients with drug sensitive disease may develop drug resistant tuberculosis if they fail to take antituberculosis medications as prescribed, as well as TB patients who have been prescribed an ineffective treatment plan. TB cases diseased with MDR-TB can transmit the drug resistant infection to other individuals.

What is the treatment for multidrug-resistant tuberculosis?

For patients with disease due to drug resistant organisms, expert consultation from a specialist in treating drug resistant TB should be obtained. Patients with drug resistant disease should be treated with drugs to which their organisms are susceptible. The effectiveness of treatment for latent infection with MDR-TB is uncertain.

What can be done to prevent the spread of MDR-TB?

Ensuring people with MDR-TB take all their medication and teaching patients to cover their mouth and nose when coughing and sneezing can reduce the risk of spread of MDR-TB. In addition, directly observed therapy should be used to ensure patients complete the recommended course of therapy.

Revised: June 2007

Hepatitis A, B, and C: Learn the Differences

	Hepatitis A caused by the hepatitis A virus (HAV)	Hepatitis B caused by the hepatitis B virus (HBV)	Hepatitis C caused by the hepatitis C virus (HCV)
How is it spread?	HAV is found in the feces (poop) of people with hepatitis A and is usually spread by close personal contact (including sex or living in the same household). It can also be spread by eating food or drinking water contaminated with HAV and by traveling internationally where HAV infection is occurring.	HBV is found in blood and certain body fluids. The virus is spread when blood or body fluid from an infected person enters the body of a person who is not immune. HBV is spread through having unprotected sex with an infected person, sharing needles or "works" when shooting drugs, exposure to needlesticks or sharps on the job, or from an infected mother to her baby during birth. Exposure to infected blood in ANY situation can be a risk for transmission.	HCV is found in blood and certain body fluids. The virus is spread when blood or body fluid from an HCV-infected person enters another person's body. HCV is spread through sharing needles or "works" when shooting drugs, through exposure to needlesticks or sharps on the job, or sometimes from an infected mother to her baby during birth. It is possible to transmit HCV during sex, but it is not common.
Who should be vaccinated?	• People who wish to be protected from HAV infection • All children at age 1 year (12–23 months) • Men who have sex with men • Users of street drugs (injecting and non-injecting) • People who travel or work in any area of the world except the U.S., Canada, Western Europe, Japan, New Zealand, and Australia • People who will have close personal contact with an international adoptee, from a country where HAV infection is common, during the first 60 days following the adoptee's arrival in the U.S. • People with chronic liver disease, including HCV • People working with HAV in a laboratory • People with clotting factor disorders (e.g., hemophilia)	• All infants, children, and teens ages 0–18 years • Any adult who wants to be protected from HBV infection • Sexually active people who are not in long-term, mutually monogamous relationships • Men who have sex with men • People seeking evaluation or treatment for a sexually transmitted disease • Healthcare or public safety workers who might be exposed to blood or body fluids • Residents and staff of facilities for developmentally disabled people • Adults under 60 years of age with diabetes • Dialysis and pre-dialysis patients • People infected with HIV • People in close personal contact (i.e., household or sexual) with someone who has chronic HBV infection • Current or recent injection-drug users • Travelers to regions of the world where hepatitis B is common (Asia, Africa, the Amazon Basin in South America, the Pacific Islands, Eastern Europe, or the Middle East); • People with chronic liver disease	**Who should be tested?** There is no vaccine to prevent HCV. Testing for HCV is recommended for the following groups of people. • People born during 1945–1965 • Injecting drug users • Recipients of clotting factors made before 1987 • Hemodialysis patients • Recipients of blood or solid organ transplants before 1992 • Infants born to HCV-infected mothers • People with undiagnosed abnormal liver test results Although HCV is not commonly spread through sex, individuals having sex with multiple partners or with an infected steady partner may be at increased risk of HCV infection.
Symptoms	Viral hepatitis symptoms are similar no matter which type of hepatitis you have. If symptoms occur, you might experience any or all of the following: jaundice (yellowing of the skin and whites of the eyes), fever, loss of appetite, fatigue, dark urine, joint pain, abdominal pain, diarrhea, nausea, and vomiting. Very rarely, a recently acquired case of viral hepatitis can cause liver failure and death. Sometimes in these instances, a liver transplant (if a liver is available) can save a life. Note: For all types of viral hepatitis, symptoms are less common in children than in adults, and for people of any age with HCV infection, they are less likely to experience symptoms.		
	Incubation period: 15 to 50 days, average 28 days	**Incubation period:** 60 to 150 days, average 90 days	**Incubation period:** 14 to 180 days, average 45 days
Chronic infection	There is no chronic infection. Once you have had HAV infection, you cannot get it again. About 15 out of 100 people infected with HAV will have prolonged illness or relapsing symptoms over a 6–9 month period.	Chronic infection occurs in up to 90% of infants infected at birth; in about 30% of children infected at ages 1–5 years; and less than 5% of people infected after age 5 years. In the U.S., 2,000 to 4,000 people die each year from hepatitis B. Death from chronic liver disease occurs in 15%–25% of chronically infected people People who have chronic HBV infection have a much higher risk of liver failure and liver cancer.	Chronic infection occurs in 75%–85% of newly infected people and 70% of chronically infected people go on to develop chronic liver disease. In the U.S., an estimated 8–10,000 people die each year from HCV. People who have chronic HCV infection have a much higher risk of liver failure and liver cancer. Chronic HCV-related liver disease is the leading cause for liver transplant.
What treatment helps?	• There is no treatment for HAV other than supportive care. • Avoid alcohol. It can worsen liver disease.	• People with chronic HBV infection should have a medical evaluation for liver disease every 6–12 months. Several antiviral medications are currently licensed for the treatment of individuals with chronic HBV. These drugs are effective in preventing serious liver problems in up to 40% of patients, but the drugs do not get rid of the virus. Liver transplant is the last resort, but livers are not always available. • Avoid alcohol. It can worsen liver disease. • There is no medication to treat recently acquired HBV infection.	• People with chronic HCV infection should have a medical evaluation for liver disease every 6–12 months. There are drugs licensed for the treatment of individuals with chronic HCV infection. Combination therapy is currently the treatment of choice and can eliminate the virus in approximately 40–50% of patients with genotype 1 (the most common genotype in the U.S.). • Get vaccinated against hepatitis A and B. • Avoid alcohol. It can worsen liver disease. • There is no medication for the treatment of recently acquired HCV infection.
How is it prevented?	• Get vaccinated! Safe and effective vaccines to prevent HAV infection have been available in the U.S. since 1995. • Always wash your hands with soap and water after using the toilet, changing a diaper, and before preparing or eating food. • For a recent exposure to someone with HAV or if travel is soon (leaving in less than 2 weeks) to an area of the world where hepatitis A is common, see your healthcare provider about your need for hepatitis A vaccine or a dose of immune globulin (IG).	• Get vaccinated! Hepatitis B vaccination is the best protection. Three shots are usually given over a period of six months. • Whenever a woman is pregnant, she should be tested for hepatitis B (HBsAg blood test); infants born to HBV-infected mothers should be given HBIG (hepatitis B immune globulin) and vaccine within 12 hours of birth. • Tell your sex partner(s) to get vaccinated too, and always follow "safer sex" practices (e.g., using condoms).	• There is no vaccine to prevent HCV infection. • HCV can be spread by sex, but this is not common. If you are not in a mutually monogamous relationship, use latex condoms correctly and every time to prevent the spread of sexually transmitted diseases. (The efficacy of latex condoms in preventing HCV infection is unknown, but their proper use may reduce transmission.) In addition to getting hepatitis A vaccine, you should also get hepatitis B vaccine.

www.immunize.org/catg.d/p4075.pdf • Item #P4075 (8/12)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

guidance & counseling services
950 South Oyster Bay Road, Hicksville, New York 11801-3511 • Tel: 516 822-6111 • Fax: 516 396-0553 • www.centralnassau.org

HIPAA PRIVACY NOTICE

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.

INTRODUCTION

We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the front desk at the Agency or you can access it on our website at www.centralnassau.org.

PERMTTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations.* For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- ***Treatment*** means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a psychiatrist treating you may need to know if you have a particular medical condition because such condition may affect the type of medication he/she prescribes
- ***Payment*** means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, prior to providing healthcare services, we may need to provide information to your insurance company about your condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the insurance company for the services rendered to you, we can provide the insurance company with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.
- ***Health care operations*** means the support functions of the client, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to client comments and complaints, practitioner reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many clients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, therapists, nurses, social workers, technicians, students and others for review and learning purposes. In addition, we may remove information that identifies you from your client information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

will obtain a written authorization from you prior to using your health information for research.

- We will use or disclose protected health information about you when required to do so by applicable law.

[*Note*: **In accordance with applicable law, we may disclose your protected health information to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Agency as required by applicable law.**]

- We may contact you to provide appointment reminders for treatment or medical care.
- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may disclose to your family or friends or any other individual identified by you protected health information directly related to such person's involvement in your care or the payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick up filled prescriptions and similar forms of protected health information when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
- We may contact you as part of our fund-raising and marketing efforts as permitted by applicable law.
- We may use or disclose your protected health information for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all clients who received a particular medication. All research projects are subject to a special approval process that balances research needs with a client's need for privacy. When required, we

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

- **Organ and Tissue Donation**. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans**. If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **Worker's Compensation**. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.
- **Public Health Activities**. We may disclose health information about you for public health activities, including disclosures:
  - * to prevent or control disease, injury or disability;
  - * to report child abuse or neglect;
  - * to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
  - * to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - * to notify the appropriate government authority if we believe that an adult client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the client agrees or when required or authorized by law.
- **Health Oversight Activities**. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit

programs, and compliance with civil rights laws or regulatory program standards.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the Agency is given assurances that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement**. We may release health information if asked to do so by a law enforcement official:

  * In response to a court order, subpoena, warrant, summons or similar process;
  * To identify or locate a suspect, fugitive, material witness, or missing person;
  * About the victim of a crime under certain limited circumstances;
  * About a death we believe may be the result of criminal conduct;
  * About criminal conduct on our premises; and
  * In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors**. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about clients to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities**. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

- **Protective Services for the President and Others**. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct special investigations.

- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **Serious Threats**. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: **HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.**

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to your therapist.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to your therapist.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Agency records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the

access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to your therapist. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records or other records used to make decisions about you;

(iii) is not available for inspection as set forth above; or

(iv) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit your request in writing to your therapist, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;

(ii) incident to a use or disclosure otherwise permitted or required by applicable law;

(iii) pursuant to a written authorization obtained from you;

(iv) to persons involved in your care or for other notification purposes as provided by law;

(v) for national security or intelligence purposes as provided by law;

(vi) to correctional institutions or law enforcement officials as provided by law;

(vii) as part of a limited data set as provided by law; or

(viii) that occurred prior to April 14, 2003.

To request an accounting of disclosures of your health information, you must submit your request in writing to your therapist. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact our **Privacy Officer at 822-6111**. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please **our Privacy Officer at 822-6111.**

This notice is effective as of April 14, 2003.

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Can be Used.** Your electronic health information can only be used by your treatment provider to:
   - Provide you with medical treatment and related services
   - Evaluate and improve the quality of medical care provided to all patients.
   - Notify your treatment providers if you have an emergency (e.g., go to an emergency room)

2. **What Types of Information About You Are Included?**

   If you give consent CENTRAL NASSAU GUIDANCE AND COUN. SERV., INC. can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may includes information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where Health Information About You in PSYCKES Comes From.**
   If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.**
   Only these people may access information about you: CENTRAL NASSAU GUIDANCE AND COUN. SERV., INC.'s doctors and other providers who are involved in your care; health care providers who are covering or on call for CENTRAL NASSAU GUIDANCE AND COUN. SERV., INC.'s ; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **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 Ariel Coffman/Compliance Officer at (516) 396-2727; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.**
   Any electronic health information about you may be re-disclosed by CENTRAL NASSAU GUIDANCE AND COUN. SERV., INC. 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.

7. **Effective Period.**
   This Consent Form will remain in effect until 3 years after the last date you received any services from CENTRAL NASSAU GUIDANCE AND COUN. SERV., INC., 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 a Withdrawal of Consent Form and giving it to Ariel Coffman/Compliance Officer__. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling Ariel Coffman at (516) 396-2727. Note: Organizations that access your health information through CENTRAL NASSAU GUIDANCE AND COUN. SERV., INC. 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.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.