S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

Welcome to S&H Youth and Adult Services

S&H Youth and Adult Services, Inc dedicated providers and staff are committed to ensuring that you receive the highest quality behavioral health services possible. This Patient Agreement establishes guidelines for your participation in treatment with us. Please read the entire Agreement and ask the front desk staff if you have any questions.

Initial Evaluations/Annual Evaluations
A psychiatric evaluation or medication evaluation is a clinical interview conducted by the provider at the beginning of treatment and yearly there after, to diagnose behavioral health problems and determine if medication is appropriate for treatment. The evaluation is usually a 45-90 minute session. The purpose of this session is to obtain a detailed history and perform a comprehensive examination. Your (or your child's) provider may request information from other health care providers and school before making a definitive diagnosis and/or treatment recommendations.

Follow-Up Sessions
Following the initial evaluation, your (or your child's) provider will discuss their assessment with you and make recommendations regarding medication(s) and/or psychotherapy. Your provider may request a blood test or an EKG prior to starting you on a particular medication. If your provider determines medication is appropriate for your treatment, our staff will schedule you for follow-up sessions as indicated during the initial phase of treatment. In these sessions, your provider will carefully monitor your (or your child's) response to the medication(s) prescribed and any side effects. These follow-up sessions typically last 15-30 minutes, although they may take somewhat longer in the early stages of treatment.

Regular Attendance
The relationship between a provider and his/her patient is a partnership and regular attendance at appointments is a critical part of your care. Although regularly scheduled visits with your provider may at times feel burdensome, this commitment helps ensure that you receive the highest quality care possible.

Late Arrivals
If you arrive late for a scheduled appointment and your provider determines that there is enough time remaining, they will see you for the remainder of your appointment time. That said, your provider may also request that you schedule an additional appointment with them.

No Show & Late Cancellation Policy*
We reserve your appointment time specifically for you and you alone. Appointments canceled with less than (2) business days' notice may be subject to a fee. Please be advised that after you no show to or late cancel three (3) scheduled appointments, your provider may terminate their relationship with you. We also understand that your time is valuable. For this reason, our office staff will call or text you to remind you of scheduled appointments.

Children and Appointments
Please note a parent, guardian, or caretaker should be with children in our waiting area at all times. Parent, guardian, or caretaker must be present for all psychiatric services.

Emergencies and Urgent Consultations
For your benefit, a staff person will be available each day after office hours in case of a behavioral health crisis emergency. Our office is open Monday-Friday from 8:30am-5:00pm. After hours on-call staff can be reached by calling our office directly (866-495-3651) and following the prompts. In the event of a life-threatening emergency, please call 911 or go directly to the emergency room.

Medications
Our providers typically evaluate adults for one session and children for up to two sessions before determining whether medication is indicated for care. For child patients, the decision to start a medication may not be made during the first session and may be deferred until the child's second session to allow the provider adequate time to obtain a full history and review any requested medical or school records.

To ensure the best response to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing it with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment please call our office one week prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, canceled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication.

I have accessed, read, and understand my rights and responsibilities. I have been provided access to download a copy of the Service Recipient Handbook. By signing this form, I confirm that I read the orientation and written documentation by S&H Youth and Adult Services, Inc. that includes the following policies and procedures:

- Program Descriptions/Service Definitions
- Admission and Discharge Policy
- Provider Choice
- Person Centered Plan
- Client Rights and Responsibilities
- Notice of Privacy Practices
- Complaints and Grievance
- Confidentiality
- First Responder Crisis Response
- Record Management
- Suspension and Expulsion
- Search and Seizure
- Physical Restraints/Interventions
- Transportation

I have read and agree to this Patient Agreement in its entirety

I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____

Patient Signature | Date

_____ _____

Patient Name | Patient Date of Birth

If you are signing this Patient Agreement as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

_____ _____

Signature | Date

_____

Name

S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

Consent to Treatment

I am voluntarily seeking behavioral health services, including medication management, MAT, and/or psychotherapy, from S&H Youth and Adult Services, Inc for the purpose of diagnosis and treatment, and recovery services. I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that S&H Youth and Adult Services, Inc providers include psychiatrists, psychiatric mental health nurse practitioners, physician assistants, psychologists, licensed therapist, certified substance use counselors, and peer support specialist. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care,substance use treatment, peer support and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

Client Rights and Responsibilities: I understand I have access to the handbook that explains Rights; Confidentiality; Recipient Responsibility; and policy and procedures that include Grievance, Search and Seizure, and Suspension and Expulsion. I understand that I may ask questions or concerns. I understand all recipient information is confidential and not divulged to any person, or agency outside S&H Youth and Adult Services, Inc without authorization. I understand I have the right to provider choice. I may decide not to work with S&H Youth and Adult Services, Inc and leave services at any time.

My signature signifies the offer of provider choice and receipt of handbook. My signature confirms I have access to read the written documentation that includes the following policies and procedures: Program Descriptions/Service Definitions; Admission and Discharge Policy; Provider Choice; Person Centered Plan; Client Rights and Responsibilities; Notice of Privacy Practices; Complaints and Grievance; Confidentiality; First Responder Crisis Response; Record Management; Suspension and Expulsion; Search and Seizure; Physical Restraints/Interventions; and Transportation. I understand that I may ask questions about anything I have read and request an explanation to my understanding by a qualified employee.

My signature confirms I understand that if the patient is a minor under the age of 21 or has a legal guardian, the parent, guardian, or caretaker must sign to consent to treatment on the patient's behalf. I must indicate my authority and sign below. I also understand that if I share legal custody of the patient, by signing this consent form I am representing that all parties who have legal custody of the patient have been made aware of, and consent to the patient's treatment. I understand that if I am my own legal guardian, I have the right to alone consent to outpatient behavioral health treatment with S&H Youth and Adult Services, Inc and therefore must sign this consent form in order to be treated by S&H Youth and Adult Services, Inc .

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent to treatment at any time.
I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Patient Signature Date

_____ _____
Patient Name Patient Date of Birth

If you are signing this Consent to Treatment as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

_____

S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

Acknowledgment of Financial Responsibility & Credit Card Authorization

I hereby assign payment of my insurance benefits to S&H Youth and Adult Services, Inc and authorize S&H Youth and Adult Services, Inc to disclose my health information to my insurance company in order to obtain payment for services rendered to me. I understand that I/the legal guardian am financially responsible for all charges not covered by an insurance plan, including copays and deductibles and no show and late cancellation fees, which are due at the time of the visit.

I understand that S&H Youth and Adult Services, Inc does not accept checks. All payments must be made by cash, credit, or money order. I authorize S&H Youth and Adult Services, Inc to keep my credit card information below on file and charge my credit card for amounts owed by me. I understand that I will be sent receipts for credit card charges via mail or e-mail and that such charges will appear on my credit card statement.

Insurance and Credit Card Information

I understand that I am responsible for providing S&H Youth and Adult Services, Inc with accurate and complete insurance information. I also understand that I am required to notify S&H Youth and Adult Services, Inc of any changes in my insurance coverage or credit card information and will be personally responsible for the cost of my care if I provide inaccurate or incomplete insurance information to S&H Youth and Adult Services, Inc or my coverage or credit card lapses.

I understand that if my behavioral healthcare is paid for in full or in part by a managed care firm, there are limitations to my rights as a patient imposed by the contract of the managed care firm. These may include their decision to limit the number of treatment sessions available, to decide the time period within which the patient must complete treatment, to require you to use medication if their reviewing professional deems it appropriate. They require detailed reports of your progress in treatment, & copies of your case file. S&H Youth and Adult Services, Inc does not have control over any aspect of their rules. S&H Youth and Adult Services, Inc will maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment.

Past Due Balance

I understand that if I have a past due balance, I may establish a payment plan with S&H Youth and Adult Services, Inc , with which I must comply in order to continue to be seen by my provider. I understand that S&H Youth and Adult Services, Inc requires me to keep a balance of under $100 in order to continue to be seen by my provider and that if I fail to do so, I may be terminated by my provider for non-payment.I understand that this Acknowledgement of Financial Responsibility & Credit Card Authorization may be revoked at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

Name of Credit Card Holder Date

/

Credit Card Number Exp. Date (mm/yy) Security Code Zip Code

Patient Signature Date

Patient Name Patient Date of Birth

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____

Approved Interventions

I understand that S&H Youth and Adult Services, Inc DOES NOT PERMIT PHYSICAL RESTRAINTS. S&H Youth and Adult Services, Inc permits its staff to use certain specific interventions to contain aggressive or threatening behavior displayed by patients. I understand the following interventions have been approved for use of S&H Youth and Adult Services, Inc.

Voluntary Time Out. S&H Youth and Adult Services, Inc employs a treatment approach that is based on positive reinforcement and least restrictive techniques (hands off) for the containment of aggressive behavior. When imminent danger is present, S&H Youth and Adult Services, Inc staff may ask the patient to take a voluntary time out.

Therapeutic crisis Response (ICV/Mobile Crisis). The SHYAS therapeutic crisis response may also be employed for approved clinical treatment reasons and used as a planned intervention as approved by the consumer or legal guardian and consumer's treatment team. When/if therapeutic crisis response is necessary to manage dangerous behaviors, or used as a planned intervention, S&H Youth and Adult Services, Inc will follow its policy of notification of the legal guardian (if applicable) and other designated persons within approved timeliness.

☐ I authorize S&H Youth and Adult Services, Inc to use intervention techniques of observation, audio/video taping during the course of my treatment for the purpose of supervision, training, research, and quality assurance and improvement of Service.
☐ I authorize S&H Youth and Adult Services, Inc to use intervention techniques of photography during the course of my treatment for the purpose of marketing, service recording, supervision , training, research, and quality assurance and improvement of Service.
☐ I authorize S&H Youth and Adult Services, Inc to use intervention techniques of Transportation during the course of service for treatment purposes access to care, supervision , training, research, and quality assurance and improvement of Service.

I understand that S&H Youth and Adult Services, Inc must use the intervention techniques of Record-keeping during the course of my treatment for the purposes maintaining clinical documentation (everything staff does with, for, and on behalf of the patient). Staff will keep records of what interventions happened during visit or session, the topics discussed, and the patients response to the intervention and topics discussed.

I understand that under the provisions of the Health Care Information Act of 1992, you have the right to a copy of my file at any time. I have the right to request that staff correct any errors in the file. I have the right to request that I make a copy of the file available to any other health care provider with a written request.

hereby authorize the transmission of my protected health information via e-mail as described above. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Patient Signature Date

_____ _____
Patient Name Patient Date of Birth

_____
Email Address

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____

S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

E-Mail and Text Authorization

I hereby request that S&H Youth and Adult Services, Inc communicate with me regarding my treatment via electronic mail, text, or e-mail.

I understand that this means S&H Youth and Adult Services, Inc staff will transmit my protected health information, such as information about my appointments, diagnosis, medications, progress, and other individually identifiable information about my treatment, via e-mail. I understand there are risks inherent in the electronic transmission of information by text or e-mail, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered. I further understand that any protected health information transmitted via e-mail pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error free and its confidentiality may be vulnerable to access by unauthorized third parties, neither S&H Youth and Adult Services, Inc nor my provider shall have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the text or e-mail of information by S&H Youth and Adult Services, Inc to me.

After being provided notice of the risks inherent in the use of text or e-mail to transmit protected health information, I hereby expressly authorize S&H Youth and Adult Services, Inc to communicate via text or email with me, which will include the electronic transmission of my protected health information. I understand that this E-Mail and Text Authorization will remain in effect until I revoke it by submitting a notice to S&H Youth and Adult Services, Inc in writing.

I hereby authorize the transmission of my protected health information via e-mail as described above. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Patient Signature Date

_____ _____
Patient Name Patient Date of Birth

_____
Email Address

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____

S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

Consent to Telemedicine

I hereby consent to the use of telemedicine/telehealth services by S&H Youth and Adult Services, Inc. I understand that telemedicine/telehealth services involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than me. I understand I have all of the following rights with respect to telemedicine:

Patient Choice. I have the right to withhold or withdraw my consent to tele services at any time without affecting my right to future treatment.

Access to Information. I have the right to inspect and receive copies of all medical information transmitted during a telemedicine consultation. I understand that my telemedicine/telehealth provider will communicate my relevant health information to physicians and other health care practitioners involved in my treatment who are located in different offices or clinics, such as my peer support specialist, counselor, primary care physician or therapist.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine, that I will not be recorded, and that no information from my telemedicine consultations which identifies me will be disclosed to third parties without my consent.

Potential Risks. I understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted, and stored pursuant to the telemedicine consultation. I understand that telemedicine/health service is an alternative to in-person treatment and S&H Youth and Adult Services, Inc may recommend I discontinue telemedicine and receive in-person treatment in certain circumstances. I understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are not listed here.

Benefits. I understand that I can expect benefits from telemedicine, but that no particular results can be guaranteed. I understand that telemedicine may provide me with access to behavioral health services that otherwise would not have been available to me.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Patient Signature Date

_____ _____
Patient Name Patient Date of Birth

_____
Email Address

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____

Consent to Obtain Medication History

S&H Youth and Adult Services, Inc uses an electronic platform in its EHR to electronically prescribe medications to patients. Using this platform, providers can transmit prescriptions to a patient's desired pharmacy electronically from the point-of-care. EHR also allows providers to obtain a patient's prescription medication history upon their consent. This information helps providers to identify potential medication issues, such as drug interactions and duplicate prescriptions.

I hereby authorize S&H Youth and Adult Services, Inc to request and use my prescription medication history collected from other healthcare providers, third-party payers (i.e. my insurance company), and pharmacies for treatment purposes.

I understand that this Consent to Obtain Medication History will remain in effect until I provide written notice of cancellation to S&H Youth and Adult Services, Inc.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____

HIPAA Notice of Privacy Practices

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer at the number listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart. By law, the medical practice is required to ensure that your protected health information (referred to in this Notice of Privacy Practices as "PHI," "medical information" or "health information") is kept confidential. PHI consists of information created or received by the medical practice that can be used to identify you. It contains data about your past, present or future health or condition, the provision of health care services to you, or the payment for such services. The medical practice can use or disclose your PHI under the following circumstances:

1. Treatment. We may use or disclose your PHI in order to provide your medical care. For example, we disclose medical information to our employees and others within the medical practice who are involved in providing the care you need. In addition, we may share your medical information with other physicians or other health care providers who are not part of the medical practice and who will provide services to you. Or, we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

2. Payment. We may use and disclose PHI to obtain payment for the services we provide. For example, we might send PHI to your insurance company if required to obtain payment for services that we provide to you.

3. Appointment Reminders. We will use the home and work numbers that you provide to us in order to make or confirm your appointments. Unless you request otherwise, our staff will leave messages at these numbers with either appointment information or requests to contact us. We may also contact you to discuss your treatment, treatment alternatives or other health-related benefits or services we offer that may be of interest to you.

4. Health Care Operations. We may use and disclose your PHI as needed to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits (including fraud and abuse detection and compliance programs) and business planning and management. Under HIPAA, we may share your PHI with our "business associates" that perform administrative or other services for

us. An example of a business associate is our billing services company. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your PHI.

5. Notification and Communication with Family. We may disclose to a family member, your personal representative or another person responsible for your care, the PHI directly relevant to that person's involvement in your care or about your location, your general condition or death. In the event of an emergency, we may disclose information to public service organizations to facilitate your care. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. For example, we may use or disclose PHI when the law requires us to report abuse, neglect or domestic violence, respond to judicial or administrative proceedings, respond to law enforcement officials or report information about deceased patients.

7. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for public health activities such as: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; and reporting to the Food and Drug Administration problems with products and reactions to medications.

8. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

9. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your PHI in the course of an administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

10. Law Enforcement. To the extent authorized or required by law, we may disclose your PHI to a law enforcement official for purposes such as complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correctional institution as authorized or required by law.

11. Public Safety/National Security/Protective Services. We may, and are sometimes required by law, to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims and for other public safety

purposes. Moreover, as authorized or required by law, we may disclose your PHI for national security or intelligence purposes or to authorized federal officials so they can provide protection to the President or other authorized persons or foreign heads of state.

12. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

13. Minors. If you are an unemancipated minor under California law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal and ethical responsibilities.

14 Sale of PHI. We are prohibited from disclosing your PHI in exchange for direct or indirect remuneration unless we have obtained your prior authorization to do so.

15. Marketing. We must obtain your authorization before using or disclosing your PHI for marketing communications that involve financial remuneration. The authorization must disclose the fact that we are receiving financial remuneration from a third party.

16. With Authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Please note that although certain disclosures described above do not require your prior authorization under HIPAA, under California law we cannot make certain disclosures listed above unless you authorize the disclosure or the requesting party submits to you and us a signed, written request in accordance with Cal. Civ. Code §56.104. Moreover, additional limitations exist with respect to our ability to re- disclose certain records that we receive from outside providers.

B. When SHYAS May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose PHI without your written authorization. If you do authorize this medical practice to use or disclose your PHI, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit, what limitations on our use or disclosure of that information you wish to have imposed and to whom the limits should apply. We reserve the right to accept or reject your request, unless you paid in full out of pocket for a healthcare item or service and you request that we do not notify your health plan that you have obtained such items or services. In that case, we must comply with your request. To the extent we have the right to accept or reject your request, we will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a post office box or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want o inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. In such an event, we will notify you in writing of the reason for the denial, whether you have the opportunity to have the denial reviewed and if so, the process for reviewing the denial. In most cases, there is an opportunity to review the denial. We will comply with the outcome of the review.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your health information made by this medical practice for a period of up to six years. For example, we are not required to provide you with an accounting of disclosures made to you, for treatment purposes, made with your authorization and for certain other purposes. To obtain an accounting of disclosures, you must submit your request in writing. You are entitled to one accounting within any 12-month period. If you request a second accounting in a 12-month period, we may assess a reasonable fee.

6. Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

7. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

8. Paper Copy. You have a right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer at the number listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice of Privacy Practices. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current Notice of Privacy Practices posted in our reception area. We will also post the current Notice of Privacy Practices on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this practice handles your health information should be directed to our Compliance Officer. You will not be penalized for filing a complaint about your service(s)or the management of your private healthcare information.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Acknowledgment of Receipt of Notice of Privacy Practices
Privacy Officer – 916-576-7900

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and on the medical practice's website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____

Consent to Release or Exchange of Consumer Information

Name, Address, & Phone Number of Agency, Organization or Individual Requesting Release	Name, Address, & Phone Number of Agency, Organization or Individual Releasing information (i.e. primary care, psychiatrist, previous Treatment provider, natural supports, school)
S&H Youth and Adult Services, Inc. Inc.	
714 South Main Street Suite 208	
Salisbury NC 28144	
Phone: 704-603-8285 Fax: 704-353-7901	**Phone:_____Fax:_____**

I understand that the information released may include information regarding HIV/AIDS information. I consent to the above-named agencies, organization or individuals to release, exchange, and/or communicate with one another the information that is listed below for the purposes of_____

This data shall include: (Client must initial all that apply)
__ Screening and/or Admission Assessment Evaluation
__ Treatment (Service) Plan I Diagnosis
__ Discharge Summary
__ Case Management Assessment / Plan
__ Psychiatric and or Psychological Evaluation
__ Progress (Service) Notes: Dates from _____to_____
__ Treatment report from other agencies / persons (specify): _____
__ Medication History
__ Other:_____

Client must initial if any of the above data contains substance abuse information:

_____ I understand that my records are protected under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

_____ I understand this information will be used for the development of individual services provided by community support professional and adjunct/partnering agencies used as community resources to meet my individual needs. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent will terminate upon _____(mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Consumer or Legally Responsible Person Date

_____ _____
Consumer or Legally Responsible Person Date

NOTE: In case of minor receiving substance related services, the minor must always sign the Consent for Release of Information, and when applicable, the legally responsible person

AUTHORIZATION REVOCATION

_____ I hereby choose to revoke this consent and request that it no longer be valid as of this date: ___/___/___

Consent to Release or Exchange of Consumer Information

Name, Address, & Phone Number of Agency, Organization or Individual Requesting Release	Name, Address, & Phone Number of Agency, Organization or Individual Releasing information (i.e. primary care, psychiatrist, previous Treatment provider, natural supports, school)
S&H Youth and Adult Services, Inc. Inc.	
714 South Main Street Suite 208	
Salisbury NC 28144	
Phone: 704-603-8285 Fax: 704-353-7901	**Phone:_____Fax:_____**

I understand that the information released may include information regarding HIV/AIDS information. I consent to the above-named agencies, organization or individuals to release, exchange, and/or communicate with one another the information that is listed below for the purposes of_____

This data shall include: (Client must initial all that apply)
__ Screening and/or Admission Assessment Evaluation
__ Treatment (Service) Plan I Diagnosis
__ Discharge Summary
__ Case Management Assessment / Plan
__ Psychiatric and or Psychological Evaluation
__ Progress (Service) Notes: Dates from _____to_____
__ Treatment report from other agencies / persons (specify): _____
__ Medication History
__ Other:_____

Client must initial if any of the above data contains substance abuse information:

_____ I understand that my records are protected under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

_____ I understand this information will be used for the development of individual services provided by community support professional and adjunct/partnering agencies used as community resources to meet my individual needs. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent will terminate upon _____(mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Consumer or Legally Responsible Person Date

_____ _____
Consumer or Legally Responsible Person Date

NOTE: In case of minor receiving substance related services, the minor must always sign the Consent for Release of Information, and when applicable, the legally responsible person

AUTHORIZATION REVOCATION

_____ I hereby choose to revoke this consent and request that it no longer be valid as of this date: ___/___/___

S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

SERVICE ORDER

Physician Name, Address, & Contact Info	Patient Name, Address, Contact Info, & Insurance No.

"Your Place of Security and Hope"

S&H Youth and Adult Services, Inc is a mental health and substance abuse outpatient treatment services provider. In order to provide more effective patient care and comply with State and Federal regulations, we are asking for your cooperation. We would like to inform you that the above patient has been assessed by our clinician and has been recommended for outpatient therapy treatment services. Please find the consent to release indicating patient's consent to release information below.

Patient has been diagnosed with

_____

Please acknowledge your response and send the document back via fax to 704-353-7901.

☐ I have reviewed the above patient's medical record and attached assessment. The above named **patient meets medical necessity for the recommended treatment services.**

☐ I have reviewed the above patient's medical record and attached assessment The above named **patient does not meet medical necessity for the recommended treatment services.**

☐ There are no records available for the above patient.

☐ The copy of the last three service notes and list of medications are attached for the above patient.

Comment: _____

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

By signing this referral form, I consent S&H Youth and Adult Services, Inc to release, exchange, and/or communicate with the above named physician/office. I understand that the information released may include information regarding HIV/AIDS. I understand that my records are protected under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand this information will be used for the development of individual services provided by SHYAS professionals and adjunct/partnering agency used as community resources to meet my individual needs. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier. **NOTE:** In case of minor receiving substance related services, the minor must always sign the Consent for Release of Information, and when applicable, the legally responsible person.

_____ _____

Legally Responsible Person/Consumer Signature **Date**

"THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE."

S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651

SHYAS

Your Place of Security & Hope

Communicable Disease Questionnaire

Initial: ( ) Update ( ) Name: _____ Record#_____

1. As far as you know, do you currently have **any communicable disease**?

☐**YES** ☐**NO** Explain_____
_____

2. Have you ever been diagnosed as <u>having **tuberculosis**</u>. I understand that a "yes" answer means that I need to produce a physician's release to work.

☐**YES** ☐**NO** Explain_____
_____

3. Have you been diagnosed as **having infectious hepatitis or been exposed to anyone having infectious hepatitis** in the last six weeks? I understand that a "yes" answer means that I need to produce a physician's release for treatment.

☐**YES** ☐**NO** Explain_____
_____

4. List any medications that you are currently taking:
_____
_____

5. State any physical limitations or disabilities which may interfere with your treatment participation.
Explain_____
_____

6. It is highly recommended that SHYAS members have regular tuberculosis testing and show evidence of test results. It is also understood that if I am diagnosed as having any communicable disease, it is required to report findings to the Department of Health**. I UNDERSTAND THAT I CANNOT PARTICIPATE IN TREATMENT IF I HAVE A COMMUNICABLE DISEASE.**

Patient Signature: _____Date:_____

For Office Use Only:
I have assessed this individual and am satisfied that the employee appears free of obvious medical problems which prevents program participation.

SHYAS Rep/Nurse Signature: _____Date:_____

Controlled Substance Agreement

The purpose of this contract is to establish an agreement between the clinician and patient on conditions for prescribing and use of controlled substances in the event use of these agents is deemed medically appropriate. This agreement is essential in maintaining the trust and confidence necessary in the clinician/patient relationship. Should controlled medication be a part of your treatment, the frequency and type of medication prescribed is, and must be, under the discretion of your prescribing clinician. Your treatment may require the use of controlled substances which may include, but not limited to, hypnosedatives or stimulants. The use of controlled substances carries several risks, such as physical dependency, when used on an extended daily basis.

Side effects from hypnosedatives and stimulants include, but are not limited to, drowsiness, fatigue, impaired coordination, irritability, memory impairment, lightheadedness, dizziness, sexual difficulties, depression, confusion, weakness, constipation, changes in appetite or weight, palpitations, increased heart rate and /or blood pressure, psychotic episodes, restlessness, overstimulation, insomnia, euphoria, tremor, exacerbation of tics, dry mouth or possible worsening of clinical psychiatric condition. Taking more controlled substances than as prescribed and/or combining controlled medications with other medications, illicit substances or alcohol could result in life-threatening conditions including but not limited to respiratory failure, cardiac failure, coma, organ damage or even death. Another serious problem associated with prescribing controlled medications is the diversion of controlled substances for resale. Diversion is defined as use of prescription medications for nonmedical recreational or illicit purposes.
Withdrawal symptoms from hypnosedatives may include, but are not limited to: insomnia, muscle cramping, vomiting, sweating, tremors, convulsions or death.
Withdrawal symptoms from stimulants may include, but are not limited to: depression, intense fatigue and sleepiness.

Tolerance can occur with these medications and is defined as requiring increasing doses of the medication to obtain the same effect. Tolerance is differentiated from addiction. Addiction involves abnormal social behavior to obtain controlled substances such as stealing, lying or abusing the medications that have been prescribed. Addiction is not typical in patients who do not have a prior history of addiction to controlled substances, alcohol or illicit substances.

The rules of this agreement may seem extremely strict and demanding. These rules are intended to protect you and others from the improper use of controlled substances. Your clinician believes that these rules are fair and necessary. Your understanding of these liabilities is important and appreciated by all your health care professionals. This agreement must be signed and returned upon your initial visit or signed at the request of your clinician or staff at Cornerstone Psychiatric Services. You may request a copy of this agreement at any time.

By signing this form, I have read, understand and agree to the following:

- All controlled substances will be taken only as prescribed.
- That I have been informed of the risks and side effects of controlled substances.
- To be seen and evaluated at least every 3 months to assess the efficacy and appropriateness of treatment.
- All controlled substances will only be prescribed for 30 day supply.
- All controlled substances will only be prescribed if there is active participation in outpatient therapy or substance use treatment program.
- To contact your clinician to seek approval should I feel my medications should be altered in any way other than prescribed.
- Not to increase dosage of my controlled medication unless authorized by your prescribing clinician or on-call clinician.
- To exercise caution when performing activities, such as driving or operating heavy machinery.
- Not to use any illegal substances, including marijuana, cocaine, etc.
- Not to use the medication with any alcoholic beverages.
- Not to share, sell or trade my medication for any reason, including money, goods or services.
- Not to attempt to obtain controlled substances from any other health care provider without disclosing the current medications prescribed.
- To bring any remaining controlled substances in their proper containers at the request of your clinician or staff. These medications may be counted by any of the SHYAS staff.
- It is my responsibility to protect and secure any controlled medications prescribed to me, which may not be replaced if lost or stolen.
- To obtain all my controlled medications from only one pharmacy.
- To notify SHYAS office immediately should I change pharmacies and to furnish my new pharmacy with the address and telephone number of my old pharmacy.
- Your clinician or designated staff at SHYAS will access and obtain Controlled Substance medication(s) history through the use of the State of North Carolina controlled substance monitoring database.
- To authorize SHYAS and my pharmacy to fully cooperate with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or diversion of my controlled substance(s).
- To authorize SHYAS to provide a copy of this agreement to my pharmacy.
- To submit a blood or urine test, at random, and/or when requested by any SHYAS staff to determine my compliance with this contract.
- Failure to comply with this contract may result in the withdrawal of all controlled substances, which may result in referral to a detoxification and substance treatment program, as well as termination of the clinician/patient relationship.
- I agree to release the staff at S&H Youth and Adult Services, Inc. (SHYAS), from all responsibilities and obligations of the clinician/patient relationship should I breech this contract and I understand I will be terminated as a patient of SHYAS.

I have read, fully understand and agree to comply with this contract.

Patient Signature	Date
Patient Name	Patient Date of Birth

If you are signing this Acknowledgement of Financial Responsibility & Credit Card Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below. _____