

## NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act I am required to provide you with this information regarding my responsibilities to you with regard to how your psychological and medical information may be used and disclosed, and how you might get access to this information. It is intended to clarify these responsibilities and rights, and please ask if you have further questions.

### Use and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your consent and without specific authorization for some purposes. Here are some definitions of the above terms:

“PHI” refers to information in your health record that could identify you.

“Treatment” is when I provide, coordinate or manage your health care and related services.

“Payment” is when I receive reimbursement for your healthcare. I am permitted to disclose certain PHI when filing insurance claims.

“Health Care Operations” are activities related to the performance and operation of my practice. They include billing service functions and case consultation activities.

“Use” applies when these activities take place within my office.

“Disclose” applies to activities outside of my office such as releasing or transferring information about you to the other parties.

### Uses and Disclosures Requiring Authorization

If I need to use or disclose your PHI for purposes other than treatment, payment or health care operations, I will need an authorization from you. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures.

For some patients, I keep psychotherapy notes. These notes are kept separate from the more general session notes I keep, and are given greater protection than PHI. These notes, if they exist in your particular case, cannot be released without your express permission.

You may revoke an authorization at any time by notifying me in writing. Exceptions to this right to revoke include:

1) If I have already relied on the authorization, or 2) If the authorization was for insurance coverage and the insurer has the right to contest the claim under the policy.

#### **Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.

Adult and Domestic Abuse: If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate county agency or a law enforcement agency. A "vulnerable adult" is someone who possesses a physical, mental or emotional infirmity or dysfunction that impairs their ability to care for themselves without assistance or protect themselves from maltreatment.

Health Oversight Activities: A state licensing board may subpoena records from me if they are relevant to an investigation it is conducting.

Judicial and Administrative Proceedings: If you are involved in a court proceedings and a request is made for information about the professional services that I have provided you and/or the reasons thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legal appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

Serious Threat to Health or Safety: If you communicate a specific, serious threat of physical violence against a specific, clear identified or identifiable potential victim. I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and

will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

Worker's Compensation: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

#### Patient's Rights and Doctor or Therapist's Duties

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and t Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

Right to Inspect and Copy: You have the right to inspect and obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny you access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive and accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

#### Doctor or Therapist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect of PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will either give you a revised notice or send one to you by mail.

**Complaints/Grievances:**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may make a written complain to Program Manager/Program Director:

Metro Social Services, Inc.  
1120 E. 80<sup>th</sup> Street Suite #202  
Bloomington, MN 55425  
(952) 854-5919

You may also send a written complain to the Secretary of the U.S. Department of Health and Human Services.

**Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on July 14, 2004. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. Prior to the change taking effect I will provide you with a revised notice.

# METRO SOCIAL SERVICES, INC.

## CONSUMER BILL OF RIGHTS

You have several rights when you are receiving services from a licensed provider. They must give you a copy of these rights on your first day of service. The provider must then explain these rights to you within 5 working days of providing service to you.

### Service Related Rights.

*THE RIGHT TO TERMINATE OR REFUSE SERVICES* - You have the right to refuse or end services. If you choose either of those options, the service provider will inform you of the results of ending or refusing services.

*THE RIGHT TO KNOW SERVICE LIMITS* - You have the right to know, in advance, any limits to the services you are to receive.

*THE RIGHT TO KNOW INTITATION/DISCHARGE TERMS* - You have the right to know the provider's policy on service starting services. You also have a right to know why the provider could discharge you. A discharge is when the provider stops giving you services and asks you to get services somewhere else. If a provider wants to stop giving you services, they must give you written notice in advance.

*THE RIGHT TO KNOW SERVICE CHARGES* - You have the right to know what the charges are for your services.

*THE RIGHT TO KNOW FUNDING SOURCE* - You have the right to know who pays for services and if you or your family has to pay any amount Service payment.

*THE RIGHT TO TRAINED/COMPETENTSTAFF* - The staff that works with you must have the training necessary to do a good job. If you and your case manager think these staff need added training and write this in your service plan, the provider must make sure staff have this training.

### Protection - Related Rights

*THE RIGHT TO PRIVATE RECORDS*- People can only look at your records or talk about you to others if you or your guardian gives permission. You have a right to know your service provider's policy about keeping your information private.

*THE RIGHT TO SEE YOUR RECORDS* - You have a right to look at your records.

*THE RIGHT TO BE FREE FROM MALTREATMENT*- Staff must do all they can to prevent you from being hurt by others. If someone mistreats you, tell a staff person, your case manager, or some other advocate.

*THE RIGHT TO BE TREATED WITH RESPECT*- Staff must treat you respectfully. They must allow you to do the things you enjoy, speak with you in a way you can understand, and be respectful of your cultural background.

*THE RIGHT TO HAVE YOUR COMPLAINTS HEARD* - If you have a problem, you have a right to have others hear about it. You can complain to anyone working for your service provider, including the supervisors. If you feel no one is listening to your concerns, tell your case manager or an advocate. The contact person for this

*THE RIGHT TO HAVE PROBLEMS RESOLVED* - If you have a problem, you have a right to know what the provider will do to take care of it. If your problem isn't solved, you can appeal. Contact your case manager, advocate or guardian to help you with this.

*THE RIGHT TO ADDITIONAL ASSISTANCE* - Whenever you need help with something and feel you are not getting the help you need, you can contact your case manager, guardian, or an advocate.

*THE RIGHT TO STAND UP FOR YOUR RIGHTS* - If you feel any of your rights aren't being met, you, your family, or your guardian have the right to insist on your rights. Your service provider cannot stop you or do anything to punish you for this.

*THE RIGHT TO REFUSE TO PARTICIPATE IN AN EXPERIMENT*- You don't have to participate in any experiment or research unless you want to. Staff must give you information about this in a way you are able to understand it and put your choice in writing.

*THE RIGHT TO A PHONE* - You have the right to use a phone privately on a daily basis to make free local calls. You may have to pay for long distance calls or call collect.

#### **Protection - Related Rights**

*THE RIGHT TO PRIVATE MAIL* - No one can open your mail or tell you who you can or can't write to, or what you can write.

*THE RIGHT TO PRIVACY WHEN MARRIED* - If your husband or wife visits you, you have a right to private visits. If you both live at the service site, you have a right to share a bedroom and a bed.

*THE RIGHT TO FRIENDS*- You can choose your own friends. You have a right to talk to your family and friends, and they can visit when they want.

*THE RIGHT TO PERSONAL PRIVACY*- You have the right to be alone in the bathroom and bedroom.

*THE RIGHT TO PLAN ACTIVITIES* -You have a right to choose, plan, and participate in activities you enjoy.

**Metro Social Services, Inc**

I have been given a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

I have been given a copy of the Client Rights & Data Privacy Statement.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\*\* Expires one year from date of signature.

Metro Social Services, Inc.

**ADMISSION AGREEMENT**

Client Name: \_\_\_\_\_ Start of Care Date: \_\_\_\_\_

Client Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONSENT FOR CARE:**

The services to be provided to me or my child by the staff of Metro Social Services, Inc. have been explained to me, I hereby consent to the staff visiting my home periodically to render home health care as ordered by my physician in a plan of treatment. I understand that the treatment plan may change and that such changes will be discussed with me. Instructions for my care will be explained to me and will become my responsibility in the absence of a home care staff member in my home.

**RELEASE OF INFORMATION:**

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, Medicare, Medicaid or another medical insurance carriers any information needed for use in determining home health care benefits or related claim. I authorize the release of medical other related information to social/health care agencies and medical equipment/supply vendors whose services may be required in conjunction with the services provided by Metro Social Services, Inc. I also authorize physician's office/clinic, hospital, nursing home, and other health facility where I have been a client to disclose any part or all of my medical record to Metro Social Services, Inc.

**REQUEST FOR PAYMENT:**

I request payment of authorized Medicare, Medicaid, or other health insurance benefits and hereby assign benefits payable on my behalf directly to Metro Social Services, Inc. I understand should payment for services provided to me by the staff or representative of Metro Social Services is not made, I will be responsible for payment of services rendered to me, and that this payment is contingent upon written notice from the company that services rendered are not authorized benefits under the Medicare, or other health insurance. I understand that I am responsible for any insurance deductible and/or co-pay.

**CERTIFICATION:**

I certify that I have read this agreement, received a copy thereof, agree with the above conditions, and am the client, or am duly authorized by the client as the client's general agent to execute the above and accept its terms. I understand that this agreement may be revoked at any time.

\_\_\_\_\_  
Signature of client or representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date



# METRO SOCIAL SERVICES, INC.

## CONSENT FOR TREATMENT

I hereby give consent for counseling and related mental health services at Metro Social Services, Inc. for myself and/or for my children listed below. I understand that I can contact the therapist working with me or my children if I have any questions or concerns. I also understand that I can revoke this consent at any time but that I must do so in writing. I have also been informed of and received the handout called Your Rights to Privacy and information regarding my privacy rights. I know that I can review it at any time with my counselor.

\_\_\_\_\_  
Printed name of client

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

### For Minors:

\_\_\_\_\_  
Printed name of child

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Printed name of parent/guardian

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

345 UNIVERSITY AVENUE WEST  
ST. PAUL, MN 55103  
OFFICE: 651-647-0647 FAX: 651-647-1075  
[www.metrosocialservices.org](http://www.metrosocialservices.org)

**Metro Social Services, Inc**

**CLIENT AND/OR FAMILY RESPONSIBILITIES**

**POLICY**

Clients shall be informed of their responsibilities related to the care or services provided at the time of admission in both written and verbal form.

**PURPOSE**

To provide sufficient information to clients and/or family members about their responsibility in the care process.

**REQUIREMENTS FOR HOMECARE**

1. The client's clinical needs can be met at home.
2. The client's home environment supports home care services
3. Client and/or family participates in the development of the plan of care and subsequent changes
4. Client and/or family have the responsibility to notify agency when scheduled visits/hours cannot be kept.
5. Client and/or family have the responsibility for supplying accurate and complete information regarding medical history.
6. Client and/or family is responsible for his/her action if the plan of care is not carried out as ordered.
7. Client and/or family is responsible to notify agency if instructions are not understood or cannot be followed.
8. Client and/or family is responsible to treat agency staff with respect and to provide a safe environment. This includes:
  - No weapons visible. All weapons in home must be locked up and guns not loaded
  - No verbal abuse or threats to persons safety
  - No sexual harassment
  - No foul language
  - No sexual innuendos
9. Client and/or family is responsible to be free of contagious disease or notify agency if such situation exists.
10. The client is able to care for self or there is a reliable caregiver to meet client needs when staffing cannot be provided or between home visits. Unforeseen problems with illness, weather, emergencies, etc. may cause the agency to be unable to provide the scheduled service.
11. Client and/or family are responsible for transportation needs in most cases. In situations where the client requests transportation, the client must provide the vehicle with insurance or be willing to pay the travel expenses of the employees if they use their own car. The transportation must be part of the client care plan and be authorized by the responsible party/payer. The agency will make the determination of transportation of clients on a case-by-case basis.
12. Household chores and duties must be client related. Agency staff will not be expected to routine wash other family members clothing, wash dishes, vacuum and dust unless specifically there for homemaking service or care for other persons in the home. The agency is not responsible for the care of anyone except those identified on the service agreement.

**I acknowledge reading, understanding and receiving a copy of the above client/family responsibilities.**

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**Client/Authorized Person Signature**

**Date**

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**MSSI Staff Signature**

**Date**

Metro Social Services, Inc.  
345 University Avenue, Suite A  
St. Paul, MN 55103  
651-647-0647

## VEHICLE DISCLAIMER

The under signed hereby does release and discharge Metro Social Services, Inc. and any of it's employees, for himself/herself, his family and his/her heirs, executors and Administrators, of and from all manner of action, cause and caused of action, and any claims for which may Accrue in the future by reason of any damage, loss, injury or suffering which may arise either directly or indirectly from the engagement and use by him/her of Metro Social Services, Inc. employee driving any member of his family (or non-member) either in a vehicle owned by the undersigned or a vehicle owned by Metro Social Services, Inc. employee. The undersigned further acknowledges receipt of lawful consideration for this release.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ : 20 \_\_\_\_ at \_\_\_\_\_ (time).

Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

**Metro Social Services, Inc.**  
345 University Avenue, Suite A  
St. Paul, MN 55103  
651.647.0647 Fax: 651.647.1075

**AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION**

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize Metro Social Services, Inc. To exchange with \_\_\_\_\_

This information will be used and/or disclosed for the following purposes:

- To enhance the services provided to me by MSSJ: community support services staff and consultants
- Individuals involved in your care or payment for your care       To obtain information from school/teachers as needed
- Other: \_\_\_\_\_

(\*Research for treatment purposes may be conditioned upon a patient's signing of this release. An authorization for research may exceed one year as provided in 45 C.F.R § 164.508(c)(v).

**I authorize the release and exchange (both releasing and obtaining) of the following protected health information:**

**Medical:**

- Medication History/Summary
- Medical Reports

**Mental Health:**

- Assessment/Diagnostic Findings
- Psychiatric Evaluation
- Psychological Evaluation
- Discharge Summary

**School:**

- Attendance Records
- Special Education Records
- Academic Records
- Pick student from school

**Legal:**

- Child Maltreatment Reports
- Court or Probation Records
- Letters/Reports/Affidavits

**Chemical Dependency:**

- History/Assessment Reports
- Treatment Records

**Other:**

- Telephone Contact
- Specify: \_\_\_\_\_
- Specify: \_\_\_\_\_

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

I understand that authorizing the release of this health information is voluntary. I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to the Clinical Director. I understand that stopping this authorization will not apply to information that has already been released or disclosed.

**Unless otherwise revoked, this authorization will expire in one year.**

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal privacy rules.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number