LifeSkills, Inc.

Client Rights

YOU HAVE THE RIGHT:

1. To consideration and respect by all members of our staff.
2. To not be discriminated against on the basis of race, color, gender, national origin, religion, age, marital status, handicap, or any other legally protected status.
3. To request a review of your medical record. (You have the responsibility to notify staff of your desire to review your record in advance. We have a responsibility to guarantee protection of confidential information about others involved. We will use our best professional judgment as we provide this information in order to protect your well-being.)
4. To receive any information necessary to give your informed consent prior to the start of any referral, procedure, and/or treatment. (You will receive individualized treatment. No participation in research will be done without your informed written consent.)
5. To refuse treatment. (However, if at any time you become dangerous to yourself or to others, we will work with the local court system to ensure safety.)
6. To privacy.
7. To confidentially in communications and records.
8. To have input into your service plan and be informed of its contents.
9. To obtain information as to any relationship this agency has with other health care and educational institutions that might assist us in providing your care.
10. To examine and receive an explanation of your bill.
11. To confidentiality of alcohol and other drug abuse records as protected by Federal law and regulations (42 CFR Part 2).
12. To file a grievance, if necessary.

Client Grievance Procedure

People supported through LifeSkills' programs, and their families, are encouraged to let us know of any concerns. Hopefully all problems can be solved at the program level and timeliness is important in addressing issues of concern. Reporting concerns and grievances will not result in retaliation or barriers to services.

If you are not satisfied or wish to express a concern we ask that you utilize the following procedure:

1. Notify your provider or staff member as soon as an issue arises. You can expect a response within (5) business days. You may receive assistance from LifeSkills staff, or an advocate of your choice at any of the following levels.
2. If you find the result unfavorable at the Program level you may contact the Divisional Vice President at 270-901-5000. For Mental Health or Substance Abuse Services contact Shelley Carter. For Developmental Services Contact Brad Schneider. You will receive a response within (10) business days.
3. If you are dissatisfied with the resolution you may Contact the Corporate Compliance Officer at 270-901-5000 Ext. 1316. You will be encouraged to state your grievance in writing to the following address: Scott Bell, LifeSkills, Inc., P.O. Box 6499, Bowling Green, KY 42102. You will receive a response within (10) business days from receipt or notification.
4. If you are not satisfied with the decisions made by LifeSkills' internal grievance process, you may contact the Department of Behavioral Health, Developmental and Intellectual Disabilities at 100 Fair Oaks Avenue, Frankfort, KY 40621 (502-564-7702) or the Cabinet for Health Services, Office of Ombudsman, 275 East Main Street 1E - B, Frankfort, KY 40621 (1-800-372-2973) or
   (1-800-627-4702 TTY).

LifeSkills, Inc.

Missed Appointment Policy

It is very important for you to keep all your scheduled appointments here at our clinic. It is important for two reasons. First, we know that good results come from regular contact with your therapist or doctor. Second, many adults and children want to be seen by our therapists and doctors, so the time we have scheduled for you is very valuable.

We ask that you give us 24-hour notice when you are unable to make a scheduled appointment. By letting us know that you will not be keeping your appointment, we can offer that time to another person. This will also assist us in rescheduling your appointment for a more convenient time.

We are committed to providing you with the best mental health services available and ask that you join us in making the most of the time that has been scheduled for you. If you have any questions or concerns about our missed appointment policy please feel free to talk to your therapist or doctor.

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.

Introduction
At LifeSkills, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you receive a service from LifeSkills, a record of your service is made. Typically, this record contains your symptoms, content of sessions, examination and test results, mental health history, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the various staff who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for research,
- A source of information for government oversight agencies charged with monitoring and improving health care in the state,
- A source of data for internal planning and quality improvement

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of LifeSkills, the information belongs to you.

You have a right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect your health record as provided for in 45 CFR 164.524 (you are entitled to one free copy of your medical record; a nominal copying fee will be charged for subsequent copies),

- Request amendment to your health record as provided for in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, or healthcare operations as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request restrictions on certain uses and disclosures of your information as provided by 45 CFR 164.522. [NOTE: While you have the right to request such restrictions, LifeSkills is not required by law to grant such restrictions]
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

LifeSkills is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Get your written authorization to disclose information for purposes other than treatment, payment or health care operations.

We reserve the right to change our practices at any time and to make the new provisions effective for all protected health information we maintain. You may request an updated copy of these information use policies at any time. Current copies of this privacy notice will always be posted conspicuously in all of our service locations.

We will not use or disclose your health information without your authorization, except as described in this notice or as otherwise allowable or required by law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact LifeSkills' Privacy Officer, Scott Bell at 270-901-5000 Extension 1316.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201

Examples of Disclosures for Treatment, Payment and Health Operations

- We will use your health information for treatment.

For example: Information obtained by a staff member involved in your treatment will be recorded in your record and used to determine the course of treatment that should work best for you. Information from your record, both written and oral will be shared among LifeSkills team members who are directly involved in your treatment.

- We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, and services provided. Only the minimum amount of information necessary to obtain payment will be sent.

- We will use your health information for regular health operations.

For example: Members of LifeSkills' staff who are not directly involved in your treatment may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Business Associates: There are some services provided in, or on behalf of, our organization through contacts with business associates. Examples include auditors, attorneys, and subcontractors. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Research. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Permission for Treatment/Services

I am the legal ◯ parent ◯ guardian ◯ client and I do herby grant my permission for the staff of LifeSkills, Inc. to render treatment and/or services to _____. Furthermore I certify that I have full legal right to grant such permission and I am not being coerced to receive these services.

Informed Consent Disclosure

You are assured confidentiality at LifeSkills, Inc. This is the foundation on which we build our trust with you and we value it highly. We will not share information about you (or those for whom you have responsibility) without your knowledge. Whenever it is necessary to share information with anyone outside of LifeSkills, we will discuss that with you and have you give permission to release such information by signing an "Authorization to use or disclose Protected Health Information" form indicating the specific information to be released and to whom it is to be released.

As noted above there are some conditions when your therapist is **required by law** to release confidential information about you with or without your permission. They include the following:

1. If your therapist has reasonable cause to believe that you intend to hurt yourself or someone else.

2. If your therapist has knowledge of or suspects a child has been abused or neglected.

3. If your therapist has knowledge of or suspects an adult who is vulnerable due to an emotional, intellectual, or physical disability has been the victim of abuse, neglect or exploitation.

4. If your therapist is subpoenaed to court and ordered by the judge to testify about you. The therapist will do his/her best to protect your right to confidentiality while complying with the court order.

Release of Information For Billing Purposes

In order to have services authorized and/or paid for by a third party (e.g. Insurance Co., Medicaid, Medicare, Department of Mental Health), it is necessary that we send certain information to them (e.g. diagnosis). In some cases, insurance benefits are managed by a "managed care company" who may require more detailed information and updates from time to time to continue certification or payment of services. When it is necessary to share such information, only information needed to certify services or access payment will be shared. Your signature below indicates that you understand this and consent to information being provided to any third party payer source. My signature below confirms I have read, discussed and understand all the above information. I further acknowledge that I have received copies of my rights and procedures to follow if I have a complaint or believe that I have been treated unfairly.

Primary Care Physician Information

To provide you the best care possible we feel it is important for all health care providers to be aware of other professionals involved with your treatment. Would you like for us to send a letter to your primary care physician informing them of your involvement with our agency?

- ◯ I have no Primary Care Physician
- ◯ I prefer not to notify my Primary Care Physician
- ◯ I would like for my Primary Care Physician to be notified.

An Authorization to Use or Disclose Protected Health Information is required if primary care physician is to be notified.

Collateral Contact and Therapy

Therapy provided to you or your loved one may need to include discussions with others involved in your or your loved one's life. This could mean discussions with significant others, siblings, parents, teachers or other mental health providers. You may be asked to sign a release of information to allow contact with one or more people that your therapist may want to include in discussion. Please indicate your preference for participating in collateral therapy. You can change your mind at any time by rescinding the release of information for the individual you were allowing LifeSkills, Inc. to contact.

- ◯ I have no objections to participating in collateral therapy at this time. I understand that a separate release of information will need to be completed for each participating individual.

- ◯ I do not wish to participate in collateral therapy at this time.

LifeSkills, Inc.

Consent for Telephone Contact

As a courtesy to clients we make appointment reminder calls alerting you to an upcoming appointment as well as inform you when it is necessary to change an existing appointment. You also have the right to refuse this service. Please mark your choice below.

- ◯ I give LifeSkills, Inc consent to make appointment reminder calls, notify me of cancelations and leave a message if I am not available.
- ◯ I do not give LifeSkills, Inc to contact me by phone. I understand that I will be notified when I arrive at the center of any changes in my appointment status.

MEDICAL CONSENT

Authorization for LifeSkills, Inc. staff to consent to emergent medical treatment in the absence of a parent or guardian.

_____ _____

Client Name SS#

_____ _____

Birth Date Parent / Guardian's Name (if applicable)

I hereby appoint any agent of: LifeSkills, Inc.
P.O. Box 6499
Bowling Green, KY 42102-6499

as a representative, during my absence, authorized to consent for all medical treatment which may be required during my absence.

_____

Preferred Medical Facility

its officials and personnel providing any medical services to the client named above may rely upon the consent of authorization executed by the above named appointee with the same force and effect as if personally executed by me.

The consent and authorization shall include and extend to all matters for which consent or authorization is required under the policies of LifeSkills, Inc.

This authorization shall be in effect until revoked by writing.

Emergency Contact Information

Emergency Contact Person: _____

Relationship: _____ Phone Number: _____

LifeSkills, Inc.

My signature below indicates that I have reviewed the following items and was given the opportunity to ask questions.

- Client Rights
- Client Grievance Procedure
- HIPAA Privacy Notice
- Missed Appointment Policy
- Permission for Treatment
- Informed Consent Disclosure
- Release of Information for Billing Purposes
- Medical Consent

Client/Parent/Representative's Signature _____

Relationship to client: ◯ Parent ◯ Guardian ◯ Other _____

_____
Signature of Witness