Bright Path
Counseling Center

"Bright Path is the Right Path"

Professional • Heartfelt • Confidential

(*Office Use*) DX:_____

APPLICATION

Name of Therapist _____ Date _____

Your Name _____ SS # _____

Maiden/Birth Name _____ Date of Birth _____ Age _____

Address _____ Zip _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

E-mail: _____ Marital Status (M/S) _____ Highest Grade Completed _____

Place of Employment: _____ Occupation: _____

Referred by: _____ Previous Counseling (Yes/No): _____

Responsible Party (must be completed if client is a minor)

Name: _____ Social Security Number: _____ - ____-_____

Relationship to Patient: (please check): ( )parent, or ( )legal guardian Date of Birth:_____

Street Address: _____ Home Number: _____

State and Zip Code_____ Cell Number: _____

PRIMARY INSURANCE INFORMATION: Plan Name: _____

Insured I.D. Number: _____ Group Number: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder ID Number: _____ Policy Holder Date of Birth: _____

SECONDARY INSURANCE INFORMATION: Plan Name: _____

Insured I.D. Number: _____ Group Number: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder ID Number: _____ Policy Holder Date of Birth: _____

I understand that I will be responsible for any deductible or remaining balance not payable by my insurance company at the time service was rendered. Further, I hereby give permission to Bright Path Counseling Center to verify my insurance coverage and to provide my insurance company with any information requested by them for the purpose of determining benefits.

Responsible Party Signature: _____ Date: _____

Witness: _____

Please Note: A No Show or Late Cancellation fee will be imposed if we are not notified of cancellations within 24 hours prior to any scheduled appointment!

___ ***Check here if you have been given copies of the program rules, regulations and you understand them.***

___ ***Please initial here that you have reviewed our HIPAA Policies***

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Financial Policy - *Please Read and Sign*

Welcome to Bright Path. We are committed to providing you with outstanding care and service during your treatment. We make every effort to assist with predetermining your insurance benefits prior to starting treatment. *However, please understand that payment for services is considered a necessary part of your treatment program.*

1. **PAYMENT: You are responsible for all fees at the time professional services are rendered to you.** We accept checks, cash, Visa, Master Card, and Discover cards. **You will be responsible for any deductible(s) and/or co-payments that are due. A finance fee of $15.00 will be charged to any balance over 30 days old. Thereafter, an additional $15 fee will be charged at 60 days and again at 90 days for a total of $45 in service fees. After 90 days, your account will be turned over to collection.** If your account is delinquent, counseling services will be interrupted until payment is received.

2. **URINE SCREENS**: For clients participating in our Alcohol/Substance Abuse Program, the lab we use for random urine screens is Medlab, Inc. **You will be required to pay a $20 fee to Bright Path to cover this service. We do not submit claims to insurance companies for urine screens**. If you would like to submit your own claim with your insurance for reimbursement, we can provide the necessary documentation.

3. **OUT-OF-NETWORK INSURANCE**: We do not file insurance claims for you if our office does not participate with your insurance carrier(s). However, our receipts are adequately itemized and coded for ease in filing for reimbursement with your carrier.

4. **DENIED CLAIMS**: We will submit insurance claims to our participating insurance companies. However, if your insurance company denies claims, **payment for services rendered is your financial responsibility.**

5. **PRE-AUTHORIZATION AND DEDUCTIBLES**: It is your responsibility to check with your insurance company before coming to our office to determine if you have a deductible and whether prior authorization is required for your insurance. **You are responsible for deductibles as well as insurance denials occasioned by failure to obtain preauthorization.**

6. **PAPERWORK RELEASE**: No paperwork can be released to outside parties without written consent unless your account is paid in full.

7. **LATE CANCELLATION AND NO-SHOW FEES**: It is our policy to charge a fee for unexcused cancellations or failure to show up to your appointment unless the appointment was canceled twenty-four (24) hours or more in advance. **These fees are posted in our front office.** Your insurance company **is not** responsible for such charges.

8. **RETURNED CHECK FEE**: There is a **$45.00** fee for checks that are returned due to insufficient funds.

9. **ATTORNEY FEES**: If we are required to engage the services of an attorney in order to collect any amount you owe us, you will be responsible for the reasonable attorney's fees and other collection expenses incurred.

If you have a balance due on your account from previous visits, please remit this balance in full before your appointment with your therapist.

Please sign below to indicate your acceptance of these terms.

_____ _____

Client's Signature Date

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PATIENT RIGHTS

1. Each client has a right to an individually designed plan of service based on his or her individual needs in which the client has participated in developing, and which includes goals that the client has agreed to work towards.

2. Each client shall be free of any personal involvement with any facility staff member.

3. Each client has the right to considerate and respectful care.

4. Each client has the right to receive services from staff that is competent, caring, and of sufficient number to provide service absolutely.

5. Each client has the right to be treated in a way that recognizes and responds to his or her cultural identity and/or sexual orientation.

6. Each client has the right to know the client services coordinator responsible for coordinating his or her care and the name of any other person providing care to him or her.

7. No client shall be treated by a staff member known to be under the influence of alcohol or illicit drugs.

8. Each client has the right to obtain from his or her service coordinator, current information concerning his/her diagnosis and treatment in terms that he or she can understand.

9. Each client has the right to receive services in a physical environment that is safe, sanitary, reflective of human dignity, conducive to effective treatment, and which appropriately safeguards the privacy and confidentiality of client-staff interaction.

10. No treatment requiring the order of a physician shall be rendered to client except upon the prior written order of a physician, based upon a personal examination.

11. Each client has a right to examine and receive an explanation of his/her bill, regardless of the source of payment.

12. Each client may object to conditions at the facility, and has a right to reasonable, prompt response from the Clinical Director. Each client also has the right to complain to the Clinical Director, and obtain from the facility staff information about how such a complaint may be filed.

13. All treatment is voluntary. There may be legal, family, or employment consequences if treatment is refused or terminated early.

14. It is our policy to charge a client for any appointment scheduled, unless we have received 24-hour notice of cancellation. Please refer to our cancellation/no show policy and our financial policy for details. Thank You.

Signature: _____ Date: _____

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CANCELING APPOINTMENTS OR

NOT SHOWING UP FOR YOUR SCHEDULED APPOINTMENTS

Bright Path Counseling Center was created as a place to meet your counseling needs in a setting filled with respect, comfort, confidentiality, professionalism and personal caring. The main ingredient that makes this possible is the outstanding professional counselors and administrative staff that we have assembled for your needs.

With great respect, we honor your journey to healing by providing quality care in a timely fashion. We also have limited space and time. Therefore, every appointment set up for you is at a premium. We therefore appreciate your return of this respect by committing to meet your appointment time. We know that you will understand the need for us to uphold the following policies:

1. **Be On Time:** Try to arrive a few minutes before your appointment so that you have the full time for your session. Therapists need to conclude your session at the appropriate time so they can complete your paperwork and be ready for the next client for their scheduled time.

2. **Not Showing Up:** If you fail to be here for your appointment without notice, please remember that this time has already been committed to you and you will be **charged a No-Show Fee.**

3. **Cancellations Without 24-Hour Notice:** Appointment times cannot be filled with someone else without sufficient notice. Therefore, you are still responsible for that time slot and will be **charged a Late Cancellation Fee.**

4. **Recurring Missed Appointments: If you are an *established client* and you have two unexcused *appointments in a row or within a month*; this indicates that you are not committed to your counseling and therefore will be discharged from Bright Path Counseling Center.** At the discretion of the multi-disciplinary team, you will be eligible to "re-enter" counseling thirty days from the discharge date, as long as your account balance has been paid in full.

5. **Emergency Cancellations:** With a doctor's written report, a car mechanic's receipt, or other **proper documentation**, we will reschedule your appointment for the next available time that your therapist can offer and waive the Late Cancellation Fee. Excused cancellations will not affect your ability to remain in counseling.

6. **Severe Weather:** Severe weather warnings must be announced on public broadcasting systems or the Internet, in order for "weather" to be a valid reason for not showing up for your appointment or canceling in less than 24 hours from the scheduled time. **You must still call to cancel the appointment in order to avoid the missed appointment Fee.**

_____ _____

Reviewed With Client Therapist Initials

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CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser **UNLESS**:

1. The patient consents in writing
2. The disclosure is allowed by a court order or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research audit or program evaluation

Violation of Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Law and Regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local authorities.

Client signature: _____ Date: _____

Witness signature: _____ Date: _____

ALSA, 'Check-In', Confidentiality, 1/2014

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Group Rules

1. Be on time. Arriving late is disrespectful to your own personal treatment plan and to the others in your group. Being on time shows respect and support.

2. You are allowed three absences from group. Any more will result in your being discharged from the group. You must notify your counselor before group starts if you will not be in group on any given day. All absences are to be made up.

3. No alcohol or other drug use before, during or after group.

4. No verbal, sexual or physical abuse. This includes name-calling or any denigrating comments.

5. Put up only – no put-downs.

6. No cross talk or interrupting.

7. Talk about your own experiences, not someone else's.

8. Everything shared in group is kept confidential. What is said in this room, stays in this room.

9. No eating in group.

10. Urine screens are done randomly.

11. No weapons allowed in group. No physical action against anyone.

12. No drug related conversations outside of group with group members. No using drugs, no supplying drugs, and no sharing drug information with group members.

13. Discuss any cravings to use during group.

14. Don't keep secrets about your drug use or any other group member's drug use.

15. Bring all concerns about self or other group members to group.

16. No Cell Phones.

I have read, agree and will abide by all of the above group rules.

_____ _____

Signature Date

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PART 822-4 COMMUNICABLE DISEASE RISK ASSESSMENT

Patient Name	Patient ID #	Date

HIV/AIDS, TUBERCULOSIS, HEPATITIS, OTHER COMMUNICABLE DISEASE RISK ASSESSMENT

			DETAILS
History of MRSA?	☐ Yes	☐ No	
History of intravenous drug use?	☐ Yes	☐ No	
History of blackouts (lacks recall of high risk behavior)?	☐ Yes	☐ No	
Did you immigrate to the US? If yes, From where?	☐ Yes	☐ No	
Do you practice high risk sexual behaviors (multiple partners, anal intercourse, unprotected sex, sex with an IV user, MSM- men having sex with men)?	☐ Yes	☐ No	

HIV Status

When was your last test?			
If test was positive, are you going to a clinic or physician? Name?	☐ Yes	☐ No	
If test was positive, did you have a T-cell and viral load done? When?	☐ Yes	☐ No	
Result of T-cell?			
Result of viral load?			
History of opportunistic infections (pneumocystis, cytomegalovirus, etc.)?	☐ Yes	☐ No	

Tuberculosis

When was your last tuberculosis skin test?	☐ Yes	☐ No	
Was the test negative or positive?	☐ Neg	☐ Pos	
If positive, were you treated?	☐ Yes	☐ No	
If treated, for how long? What medications?			
When was your last chest x-ray?	☐ Yes	☐ No	
What was the result of last chest x-ray?	☐ Yes	☐ No	

Hepatitis

History of evaluated liver functions?	☐ Yes	☐ No	
History of vaccination for Hepatitis A?	☐ Yes	☐ No	
History of vaccination for Hepatitis B?	☐ Yes	☐ No	
History of Hepatitis A test? When?	☐ Yes	☐ No	
Was Hepatitis A test positive?	☐ Yes	☐ No	
History of Hepatitis B test? When?	☐ Yes	☐ No	
Was Hepatitis B test positive?	☐ Yes	☐ No	
Were you treated? When?	☐ Yes	☐ No	
History of Hepatitis C test? When?	☐ Yes	☐ No	
Was Hepatitis C test positive?	☐ Yes	☐ No	
Were you treated? When?	☐ Yes	☐ No	
What was the latest viral load?	☐ Yes	☐ No	
If treated, what medications? How long?			
Do you drink alcohol currently?	☐ Yes	☐ No	

Syphilis

Were you ever tested for Syphilis?	☐ Yes	☐ No	
If test was positive, were you treated? When?	☐ Yes	☐ No	
What medication was used?	☐ Yes	☐ No	

Misc. STD's and Communicable Diseases

Gonorrhea	☐ Yes	☐ No	
Venereal Warts	☐ Yes	☐ No	
Herpes II	☐ Yes	☐ No	
Chlamydia	☐ Yes	☐ No	
Ringworm	☐ Yes	☐ No	
Scabies	☐ Yes	☐ No	
Shingles	☐ Yes	☐ No	
Meningitis	☐ Yes	☐ No	
Measles	☐ Yes	☐ No	
Mumps	☐ Yes	☐ No	
Chickenpox	☐ Yes	☐ No	

Patient is to be referred for follow up evaluation and/or care ☐ Yes ☐ No
If yes, Where? Facility Name and Address:
Date/Time of Referral:
Signature of Staff and date:

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NAME: _____ DATE: _____

AGE: _____

DOB: _____ MARITAL STATUS: _____

Welcome! We are delighted that you chose Bright Path Counseling Center to assess your alcohol/substance use. To help us do our jobs in a way most beneficial to you, please begin answering these questions. A counselor will be with you shortly.

Why are you here today?

Who referred you to Bright Path Counseling Center and why?

ALCOHOL/CHEMICAL DEPENDENCY HISTORY

ALCOHOL:

1. How old were you when you had your first drink?
   How many drinks did you consume in order to feel good?

2. How often did you drink at this age?

3. Explain how your drinking changed over the years:

4. Did anyone ever complain about your drinking or express concern over your alcohol use?
   Please explain:

5. What was the most alcohol you could consume on one occasion?

6. Have you ever experienced a blackout?

7. Over the past year, how often did you drink and how much alcohol did you use per occasion?

8. Have you ever tried to stop drinking?
   a.) If so, when and what type of withdrawal symptoms did you experience?

   b.) What skills/support was helpful during periods of no use?

9. When was the last time you consumed alcohol and how much did you drink?

11. Did you ever drink more than you intended or spend more money than planned on?

MARIJUANA:

1. How old were you when you first used marijuana and how much did you use in order to feel good?

2. How often did you use marijuana at this age?

3. Did anyone ever complain about your marijuana use or express concern? Please explain:

4. Explain how your marijuana use has changed over the years:

5. What was the most marijuana you could smoke on one occasion?

6. Over the past year, how often did you smoke marijuana and how much did you use?

7. Have you ever tried to stop smoking marijuana?

   a.) If so, when and what type of withdrawal symptoms did you experience?

   b.) What skills/support was helpful during periods of no use?

8. When was your last use of marijuana and how much did you use?

9. Have you ever spent more money or time using than you planned on?

CRACK/COCAINE:

1. How old were you when you first used crack/cocaine?

   How much did you use?

2. How often did you use crack/cocaine at this age?

3. Did anyone ever complain or express concern over your crack/cocaine use? Please explain:

4. Explain how your crack/cocaine use changed over the years:

5. What was the most crack/cocaine you used on one occasion?

6. Over the past year, how often did you use crack/cocaine and how much did you use per occasion?

7. Have you ever tried to stop using crack/cocaine?

   a.) If so, when and what type of withdrawal symptoms did you experience?

   b.) What skills/support was helpful during periods of no use?

8. When was your last use of cocaine and how much did you use?

9. Have you ever spent more money or time using than you planned on?

OPIATES: (Heroin, OxyContin, Hydro Codeine, etc.)

1. How old were you when you first used opiates and how much did you use?

2. How often did you use opiates at this age?

3. Did anyone ever complain or express concern over your heroin use? Please explain:

4. Explain how your opiate use changed over the years:

5. What was the most opiate you used on one occasion?

6. Over the past year, how often and how much opiate did you use per occasion?

7. Have you ever tried to stop using opiate?

   a.) If so, when and what type of withdrawal symptoms did you experience?

   b.) What skills/support was helpful during periods of no use?

8. Have you ever taken suboxone? Was it prescribed to you? If so, which doctor (s)?
9. When was your last opiate use and how much did you use?
10. Have you ever spent more money or time using than you planned on?

OTHER DRUGS:

1. List any other drugs you used (ie: LSD, opium, ecstasy, hash) including prescription drugs:

2. Have you used spice, bath salts, etc?

TOBACCO:

Do you smoke cigarettes or use smokeless tobacco?

How old were you when you first used tobacco?

How much do you use?

Have you ever tried to quit? Would you be interested in assistance on quitting?

Has your nicotine use impacted your family/health?

GAMBLING:

1. How old were you when you first gambled?

2. What types of gambling have you participated in? (i.e. instant tickets, poker, slot machines.)

3. How often do you presently gamble?

4. Has anyone expressed concerns over your gambling?

5. Have you spent more money or time than you intended on gambling?

LEGAL HISTORY:

1. List any legal problems you have had, including DWI's, jail/prison terms and dates:

2. Are you now or have you ever been on probation/parole?
   What's your NYSSID number?

3. Have you been imprisoned? How long?

4. Were you under the influence of alcohol/drugs at the time of your arrest?
   Please explain:

PRIOR TREATMENT:

1. List all alcohol/drug treatment programs you have attended, including dates:

2. List any counseling you received that was non-alcohol/drug related:

3. List any self-help programs you have attended (i.e. AA, NA, ALANON, etc.):

4. List any self-help programs you currently attend and how often you attend:

MEDICAL HISTORY:

1. When was your most recent physical exam?
2. List all medical problems you have had or are now experiencing:

3. Have you been to the emergency room in the last 6 months? If yes, please explain:

4. Have you been hospitalized in the last 6 months? If yes, please explain:

5. List all medications you are now taking:

6. Allergies?
7. When was your last TB test?
8. Are you aware that certain foods such as caffeine, sugar, chocolate, red dye, carbohydrates, etc. can cause mood changes and evoke hyperactivity in children?

RISK ASSESSMENT:

1. Have you had a blood transfusion?
2. Have you used IV drugs?
   If yes, have you shared needles?
3. Have you engaged in unsafe sexual activity?
4. Do you have a history of Hepatitis or TB?

EDUCATION/EMPLOYMENT:

1. What was the highest grade you completed? List college, vocational schools you attended and what you majored in:

2. Have you used alcohol/drugs during school or missed school to use?

3. Has use of alcohol/drugs had an impact on your education?

4. What is your current occupation and where are you employed? How long have you worked there?

5. List any other jobs you have had:

6. Have you ever lost a job, or had difficulties, due to absenteeism or tardiness as a result of alcohol/drugs?

7. Have you had/or felt you have/had a difficult time learning?

MILITARY HISTORY:

1. What branch of the service were you in?

2. What was your age when you entered and when were you discharged from the service?

3. What type of discharge did you receive?

4. Did you ever use alcohol/drugs on duty? Please explain:

5. What type of work did you do in the service?

6. Why did you leave the service?

FAMILY HISTORY:

1. Who do you currently reside with?
2. Are you married, single, divorced, separated, widow or widower?
3. How many children do you have and what are their ages?
4. Please list your parents and siblings and their ages:
5. Does anyone in your family have an alcohol/drug problem and if so, who?
6. Have you ever experienced any childhood physical, sexual or emotional abuse? If yes, please explain:
7. Has anyone in your family ever suffered from any emotional problems?
8. Has anyone in your family ever attempted or committed suicide?
9. Has a family member or friend ever expressed concerns about your use?
10. Describe your family relationships:
11. Would your family participate in treatment? If no, why not:

MENTAL STATUS:

1. Have you ever received treatment for any emotional problems? Please explain:
2. Have you ever attempted to harm yourself in any way? If so, please explain:
3. Have you ever had any suicidal thoughts? If so, please explain:
4. Have you ever attempted suicide? If so, when?
5. When you leave here today, do you feel you will harm yourself in any way?
6. Have you ever wanted to harm or kill someone else?
7. Have you ever or are you now, taking any medications for an emotional problem? If so, please list medications:
8. List your strengths:
9. List any areas you would like to improve in yourself.

SOCIAL/RECREATION:

1. Please list your areas of interest/leisure activities (ie: sports, collections, hobbies):

2. Have you decreased amount of time you spend in these activities?

3. Do most of your friends use alcohol or other drugs?

SPIRITUALITY:

1. Do you identify yourself as spiritual/religious?

2. Spiritual preference?

EMERGENCY CONTACT RELEASE FORM

Please sign consent for a person you would like notified in the event of an emergency.

Your Name _____ Your Date of Birth _____

Permission is hereby given to **Bright Path Counseling Center** and its employees to obtain information from and/or release information to:

Name of Person to Contact: _____

For the purpose of:
( ) Emergency Contact Person's Phone Number :_____

Extent or nature of information to be disclosed:

*The only information that can be released is information relating to accident or injury.

PROHIBITION ON DISCLOSURE OF INFORMATION CONCERNING ALCOHOLISM CLIENT

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42-CRD, part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as other wise permitted by such regulations, as well as Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. pts. 160 & 164. The general authorization for the release of medical or other information is NOT sufficient for this purpose. I understand that I may revoke this consent at any time by notifying the agency in writing, except to the extent that action has been taken in reliance on my consent. (Note: This pertains only to alcoholism clients.)

Bright Path Counseling Center is released from all legal responsibility that may arise from this fact.

I, the undersigned, have read the above and authorize the staff of the facility to disclose such information as herein contained.

Date _____

Signature _____ Witness_____

This authorization expires one year from its signing. A copy is as valid as the original document.

Note: Any information released through this form will be accompanied by Form A-400:
Prohibition on Redisclosure of Information Concerning Alcoholism Patient.

BACKGROUND
On May 5, 2007, the Governor signed a new law, known as "Jonathan's Law" (Chapter 24 of the Laws of 2007), which became effective immediately. This new law, stimulated by the tragic death of a 13-year old Jonathan Carey, while in residential care makes changes in the way in which certain notifications are made and information is shared, regarding incidents involving the health and safety of patients.

You have the right to refuse this request. If you choose not to identify an emergency contact please sign below.

I understand by signing below I am refusing to name and give consent for a person to be notified in the event of accident or injury.

_____ _____
Client Date

_____ _____
Witness Date

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING SUBJECT CHARGED WITH IMPAIRED DRIVING

IMPAIRED DRIVER SYSTEM (IDS)

Individual's Last Name	First	M.I.

Individual's DMV Client ID (Driver's License Number):

Individual's Case Number or File Reference:

Referring Entity's Name & Address:

Referring Entity Type	
☐ Court	☐ DDP Provider
☐ DMV	☐ OASAS Approved Provider
	☐ Motorist

INSTRUCTIONS: **1) GIVE A COMPLETED COPY OF THIS FORM TO THE INDIVIDUAL; AND**
2) ADD A COMPLETED COPY OF THIS FORM TO THE INDIVIDUAL'S CASE RECORD

I, the undersigned, hereby **CONSENT** and authorize communication between and among the above named **Referring Entity** and the following agencies:

- My OASAS approved provider: _____ ;
  (Enter Name of Provider or if unknown enter "TBD")
- My Drinking Driver Program (**DDP**): _____ ;
  (Enter Name of Program or if unknown enter "TBD")
- The New York State Office of Alcoholism and Substance Abuse Services (**OASAS**), NYS Department of Motor Vehicles (**DMV**), NYS Office of Court Administration (**OCA**) and the NYS Division of Criminal Justice Services (**DCJS**) (DCJS will receive non-personally identifying information for research purposes only);

to **DISCLOSE INFORMATION** concerning any current and/or past data pertaining to my impaired driving offense including prior conviction(s) related to impaired driving and other traffic infractions noted on my driver's abstract and the following data elements:
Motorist: DMV client ID, first two characters of current last name and last name at birth, sex, birth date and last four digits of my SSN.
Violation: violation date, court name, violation, first two characters of current last name, BAC level, indication of chemical test refusal, if any, and an indication of out of state license, if any.
Screening: provider/program name, screening date, indication of assessment referral, if any, and indication of screening tool used.
Assessment: referral source, provider/program name, assessment start and end dates and assessment status.
Treatment: provider/program name, admission date, discharge date, number of sessions and discharge status.
DDP: program name, start and status dates, indication of assessment referral, if any, and DDP enrollment status.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to share the indicated data elements for purposes of data collection, tracking, monitoring activities of providers and programs. The specific data elements disclosed to each entity will be limited to the minimum necessary for that entity to carry out its official duties related to my impaired driving offense in compliance with the NYS Vehicle and Traffic Law (VTL).

I, the undersigned, have read the above and authorize the staff of the disclosing entities named to disclose, obtain and share such information as herein specified. I further understand that, unless otherwise specified, this consent will authorize the use of data to support research and quality assurance measures for OASAS, OCA, DCJS and DMV and will remain in effect for this purpose and cannot be revoked by me for a period of ten (10) years as consistent with the record retention period in NYS VTL §201(1)(i) and the DWI offense level determination clauses of NYS VTL §1192.

I understand that disclosure of my personal information by DMV is controlled by the Federal Driver's Privacy Protection Act, 18 USC §2721 and that my signature below constitutes my authorization for DMV to disclose my personal information to the entities indicated above.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2; governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Pts. 160 & 164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Chemical Dependence Treatment Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment and/or determined ineligible for the Drinking Driver Program if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ _____
(Print Name of Individual) (Signature of Individual)

_____ _____
(Date of Signature) (Signature of Parent or Guardian of Individual, if Applicable)

NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information – OASAS Client Data System

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   _____ If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

   _____ If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information:
6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged: NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203 I authorize the above listed Entity to inform the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my enrollment in this treatment program so that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and OASAS relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services.
7. The Purpose of this disclosure is to comply with implemention of New York's Medicaid redesign initiative and to comply with mandatory federal reporting requirements. By accepting the information covered by this consent into the NYS OASAS Client Data System, NYS OASAS acknowledges that this information may not be redisclosed per 42 CFR 2.32 - Prohibition on redisclosure.
8. My health information may be disclosed for a period of three (3) years from last the date of service, or until revoked.

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW _____ DATE _____

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE _____ SIGNATURE _____ DATE _____

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and between, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me and the OASAS treatment facility identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

_____

_____

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

Bright Path
Counseling Center

"Bright Path is the Right Path"

Professional • Heartfelt • Confidential

HIPAA

We at **Bright Path Counseling Center** are committed to safeguarding your **personal health information** (PHI). PHI is any information that can identify you as an individual **and** your past, present, or future medical and/or mental health condition.

This notice, in addition to telling you about the ways that we may use and disclose your medical information, also describes your rights, and the obligations that we have regarding the use and disclosure of medical information. Federal and state law require us to:

1) Make sure your PHI is kept private;
2) Give you notice of our legal duties and privacy practices with respect to your PHI; and
3) Follow the terms of the notice that is currently in effect.

Therefore, we will release your PHI only under the following circumstances:

1) When you give us written consent to do so.
2) When we are required by a specific court order to do so.

We will make changes in our privacy policy only as required by law. We will notify you in advance of those changes, in writing.

Privacy Compliance Officer:

The privacy compliance officer at **Bright Path** is **Bonnie Merkel**. Please address all complaints and/or requests for amendments to your PHI, and/or requests for copies of your PHI, to Bonnie Merkel.

Nonpublic Personal Information:

Nonpublic Personal Information is the information you give your insurance company when you sign up for benefits, such as name, address, Social Security number, date of birth, etc. We will only provide that information to your insurance company (or companies) in order to verify benefits and obtain payment for services rendered. We will not disclose that information to any other entity unless 1) required to do so by court order; or 2) you give us written consent to do so.

Psychotherapy notes:

Psychotherapy notes have special protection under the new HIPAA regulations:

1) They can only be released under a court order that shows the necessity of their release.
2) Barring a court order, they can only be released **when the therapist determines the release to be in your best interest.**
3) Psychotherapy notes will never be released without your consent, but they may not be released to an entity you authorize, if your therapist deems it to be detrimental to your treatment.
4) Your insurance company may no longer pre-condition payment of benefits on the release of psychotherapy notes.

Please note the following restrictions, and please do not ask us to violate them:

1) We cannot acknowledge your presence and/or treatment at Bright Path Counseling Center without your written consent, or a court order. We cannot do so for family members, friends, employers, lawyers, government agencies, etc. If you want any of the above to act on your behalf, including the setting or changing of appointments, you must sign a written authorization.

2) We cannot complete any paperwork for any local, state or federal agency, for any purpose, without your consent. We cannot provide any PHI to any insurance agency other than the one(s) reimbursing us for authorized care without your specific written authorization.

Individual Rights:

1) You have the right to inspect and/or copy your PHI, when your therapist determines that such an inspection and/or copying would not be detrimental to your physical health or personal safety, and would not cause harm to another individual. **This right does not extend to psychotherapy notes, as noted above.**
2) You have a right, under law, to request an accounting of the instances in which we disclosed your PHI, other than disclosures made for the purpose of treatment, payment, and disclosures made with your authorization. However, at **Bright Path Counseling Center**, we do not make any disclosures outside of those parameters.
3) You have the right to request additional restrictions on our use and disclosure of your PHI. However, the law will not permit us to honor those additional restrictions if they keep us from receiving payment for services rendered.

Amendment:

You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We will deny your request if we did not create the information you want amended, or if we determine the current information is accurate. If we accept your request, we will make a reasonable effort to notify others, including people or organizations you name in your written request, and will include the changes in all future disclosures of your PHI. If we deny your request, we will provide a written explanation. You may then respond with a written statement of disagreement that will be attached to the information you want amended. You may contact Bonnie Merkel for a form to complete and return to us.

Safeguards:

We employ the following safeguards to insure the privacy of your PHI:

- All of our employees sign an agreement to follow our Confidentiality guidelines.
- All of our employees complete privacy training.
- We have implemented sanctions for the violation of privacy practices, up to and including loss of employment.
- We have a privacy coordinator who detects and prevents security breaches.
- All computer systems that contain personal information have security protection.
- All physical files are kept in a double-locked storage container.
- All of our therapy offices conform to state and federal privacy regulations with regards to construction and use.

Questions and Complaints:

If you want more information about our privacy practices, or feel that your privacy rights have been violated, please contact our privacy officer. You may also submit a written complaint to the Department of Health and Human Services. We will provide you with the address to file your complaint with HHS upon request.

Please contact: Bonnie Merkel
7266 Buckley Road
North Syracuse NY 13212
Phone: 315-458-0919 Fax: 315-458-0954