Tucker County Community Corrections

(Tucker Day Report)

Dustin Luzier, *Director*
Amy Cummings, *Behavioral Health Director*
213 First Street, Parsons, WV 26287
Phone: 304-478-2833
Fax: 304-478-4473

Alexis Baker, *Project Coordinator*
Teresa Kincaid, *Registered Nurse*
Brittany Mitchell, *Peer Recovery Coach*
Jessica James, *Peer Recovery Coach*
Travis Barnhouse, *Officer*
Dominique Meadows, *Case Manager*

Individual Being Referred: *(print name)* _____
Last

_____ _____ **DOB:** _____
First **M.I.**

- ❑ 12-Step
- ❑ Addictive Behavior Awareness
- ❑ Anger Management
- ❑ BIPPS
- ❑ DMV DUI Class
- ❑ Drug Screening
- ❑ EMDR
- ❑ A New Direction – Hazelden Curriculum

To include the following lessons:

- Introduction
- Criminal & Addictive Thinking
- Drug & Alcohol Education
- Socialization
- Co-occurring Disorders
- Relapse Prevention
- Release & Reintegration

- ❑ Individual Counseling
- ❑ Comprehensive Intake to determine recommended services
- ❑ Life's Healing Choices
- ❑ Life Skills
- ❑ Medication-Assisted Treatment (MAT)
- ❑ Men's Trauma
- ❑ Money Management
- ❑ NADA
- ❑ Parenting
- ❑ Peer Recovery Services
- ❑ Peer Support Group
- ❑ Psychological Evaluation Referral
- ❑ Psychiatric Evaluation
- ❑ Smart Recovery
- ❑ Education Assistance/ GED
- ❑ Women's Trauma
- ❑ Other: _____
- ❑ Inpatient Rehab/Detox (28 days)
- ❑ Long Term Rehab/Sober Living- _____ Days/Months

Date of Last Use/ # of Failed Drugs Screens: *(if applicable)*: _____

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Individual's Contact Information:

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Person Making Referral: *(Print Name)* _____

Relationship to Individual *(Check appropriate box)*

- ☐ Circuit Court
- ☐ Department of Corrections – Parole
- ☐ Defense Attorney
- ☐ Magistrate Court
- ☐ Other: _____
- ☐ Mental/Behavioral Health Care Provider
- ☐ Pretrial Release
- ☐ Probation
- ☐ Prosecuting Attorney

Referral Date: _____ **County:** _____

Case Number: _____ **DOC/CCIS#:** _____

Crime Charged: _____

Period of Sentence: _____

Please check if individual has the following: ☐ Violent Offenses ☐ Sexual Offenses

Additional Information: _____

_____

_____

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Consent to Receive Services

I hereby give my consent to receive behavioral health services from the professional staff associated or employed by Tucker Day Report.

Tucker Day Report has explained to me the proposed treatment, and alternative options, if any. However, treatment will not be delayed if any emergency exists. I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment and/or withdraw my consent from treatment at any time.

By signing I am agreeing that I have read, understood, and agree to the items contained in this document.

Signature of Patient or Parent if Minor: _____ Date: _____

Relationship to Patient: _____

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Behavioral Health Services

Informed Consent – Provider-Client Services Agreement

Welcome to Tucker Day Report (TDR). This document contains important information about professional services and business policies. Please read it carefully and make notes of any questions you might have so that they can be discussed. When you sign this document, it will represent an agreement between you and your provider.

Today's appointment will take approximately 60-90 minutes. We realize that initiating behavioral health services is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws and your rights. If you have any other questions or concerns, please ask and we will try our best to give you all the information you need.

What to expect from therapy: Psychotherapy is not easily described in general statements and varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things discussed both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you many experience uncomfortable feelings like sadness, anger, guilt, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your provider will be able to offer you some first impressions of what the work is anticipated to include and a treatment plan will follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about procedures, please discuss

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them with your therapist whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another behavioral health professional for a second opinion or referral.

Meetings: Typically, an evaluation is conducted in one to three sessions. Therapy sessions are usually scheduled weekly and last approximately 55 minutes, which is consider one therapy hour. Sessions can be more frequent, as indicated. Once an appointment hour is scheduled, you may be expected to pay for it unless you provide 48 hours advance notice of cancellation. If late cancellations or no shows occur repeatedly, you may be removed from our schedule. You will be welcome to return when you can commit to scheduled sessions, pending availability.

Fees: Intake session $180; Individual 60-minute therapy session $150; Individual 45-minute therapy session $125; Individual 30-minute therapy session $110; Group therapy session $50. I, the client, agree that my insurance may be billed. If I, the client, am prevented from attending my scheduled session and do not cancel my appointment at least 24 hours in advance, I agree may be billed a no-show fee of $50. This practice of being charged for no-shows or late cancellations is standard practice in the field and takes into account that you are not just paying for services rendered but reserving a time slot which I cannot offer to someone else on short notice.

Insurance: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing service will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions.

You should also be aware that most insurance companies require you to authorize Tucker Day Report to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the

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nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in each of our mental health counselor's office and they will be glad to let you see it to learn more about your diagnosis, if applicable.).

Sometimes Tucker Day Report will have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required,

you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions.

Confidentiality: The information you share during therapy sessions is considered confidential information and is protected by state law. As a counselor we cannot reveal to third parties whether or not you are a past or current client and cannot disclose any of the information you discuss during our sessions without first obtaining your written consent to do so.

In the following instances, however, we may be mandated or allowed to share information without your written consent:

- If during your therapy, you are deemed to pose a threat of harm to someone else or to yourself, I am allowed to collaborate with the police or a hospital to take necessary measures to prevent harm from happening.

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• If you talk about events that lead me to believe that a child under the age of 18 or an elderly or disabled person is at risk for emotional, physical or sexual abuse, neglect, or exploitation, I am required by state law to make a report to West Virginia Department of Health and Human Resources, Child Protective Services with or without your consent.

• If you are not yet 18 years of age, your parents or legal guardians may have access to your records and may authorize release of information to other parties on your behalf.

• If you disclose sexual misconduct by a previous therapist, we are required to make a report to the licensing board governing the license of the therapist.

• If a judge in a court of law orders me to release information or if I need to respond to a lawfully issued subpoena.

• If I need to cooperate with legal actions against a mental health professional by a licensing board.

• If you submit an out-of-network health insurance claim and the insurance provider needs information to authorize the therapy or the billing.

Professional Records: As you are likely aware of, providers are required to keep records of the professional services provided. Because these records contain information that can be misunderstood by someone who is not a behavioral health professional, patients are generally not permitted to review them directly. TDR adheres to the following: The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was created to provide standards for protecting the confidentiality of patients' individually identifiable health information. While the Privacy Rule gives patients a right to access their medical records, it permits providers who are covered by HIPAA to deny patients access to strictly defined psychotherapy notes. It's important to note, however, that under HIPAA providers are obligated to release these same notes to a third party if the patient requests such as an attorney, another provider.

Electronic notifications: When appointments are scheduled, automatic reminders of your appointment will be sent you used when scheduling your first appointment. By signing this consent form, I agree to receive these notifications, and understand that electronic communication is not always a confidential medium for transmitting health information.

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Contacting Me: Mental health counselors are often not immediately available by telephone. We do not answer the phone when we are with clients or otherwise unavailable. At these times, you may leave a message on our office's confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters.

In emergency situations, please dial 9-1-1 or the following **Davis Memorial Hospital (304-636-3300), Appalachian Community Health (304-636-3232), William R. Sharpe Jr. Hospital (304-269-1210).** We will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

Social Media Use: As social media is not a secure form of communication, all social media platforms such as Messenger, ShapChat, FaceBook, Instagram, etc. should be avoided when possible as a form of communication with Tucker Day Report staff members. If you need to connect with employees of the Tucker Day Report, please call the office during our regular business hours.

Coordination of Treatment: It may be necessary for your continued treatment that the Tucker Day Report office notify your Primary Care Physician and/or Psychiatrist that you are receiving treatment. If at such time such communication becomes necessary, a separate formal consent will be required from you.

Notice of Privacy Practices and Clients Rights: Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Other Rights: If you are unhappy with what is happening in therapy, we hope you will talk with to a member of our behavioral team so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request to be referred to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our mental health counselor's specific training and experience. You

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have the right to expect that our mental health counselors will not have social or sexual relationships with clients or with former clients.

Assigned Services: Our treatment team conducts a weekly clinical meeting where all new intakes are reviewed, and services are assigned. You will be contacted by a member of our behavioral health team with the date and time of your initial behavioral health appointment.

By signing I am agreeing that I have read, understood and agree to the items contained in this document.

Signature of Patient or Parent if Minor: _____ Date: _____

Relationship to Patient: _____

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Client Insurance Form

Client Name: _____ Date of Birth: _____

Patient Gender: ___M___F Social Security #: ____-_____-____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Today's Date: _____

Referring Provider: _____ Marital Status: ___S___M___D___W

Primary Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security #___ - ___- ___

Secondary Insurance: _____ Effective Date: _____

Policy # _____ Group #: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security #: ___ - ____- ____

Employer: _____ Address: _____

City: _____ State: _____ ZIP: _____

Release and Assignment:
I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to the above provider. I am aware that an agent of my insurance company or other third-party payer may be given information about the type, cost, date and provider of any services or treatment I, or my dependent receives. I understand that if payment for the services I receive are not made by the insurance company, that I am responsible for full payment. If payment is not made in a reasonable amount of time the above provider may stop my treatment.

Signature of Patient or Parent if Minor: _____ Date: _____

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Consent to Bill

I give permission for Tucker Day Report (TDR) to bill my insurance company for covered services; and to exchange information necessary to secure payment for services rendered. Such necessary information may include diagnosis, service dates, types of services and other information related to TDR's services necessary to process claims.

I understand that if an insurance payment is made directly to me for services received at TDR that I am responsible for immediately sending such payments to TDR.

I will notify TDR of any changes to my health insurance coverage as well as any denial information.

I understand that I am ultimately responsible for any balance that my insurance company does not authorize for payment.

By signing I am agreeing that I have read, understood, and agree to the items contained in this document.

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____

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Behavioral Health
Telehealth Services and Consent

With respect to telehealth services, I understand the following:

- "Telehealth" is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Technologies include videoconferencing, the internet, store- and-forward imaging, streaming media, and landline and wireless communications.
- Electronic systems used will incorporate network and software security protocols to protect confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
- To use telehealth services, I will need an internet connection and a device with a camera for video. TDR staff will explain how to log in and use any features on the telehealth platform. If Telehealth is not a good fit for me, TDR staff may recommend a different option.
- I may expect the anticipated benefits from the use of telehealth in my care, but no results can be guaranteed or assured.

I understand that there are risks and consequences from telemedicine, including, but not limited to:

- I may be asked to share personal information with the telehealth platform to create an account, such as my name, date of birth, location, and contact information.
- The possibility, despite reasonable efforts on the part of my service provider, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- At times, I could have problems with my internet, video, or sound. This may cause interruptions, poor resolution, or a delay in care due to equipment failures or deficiencies. My service provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections or other factors are not adequate for the situation. I may need to develop a backup plan with my service provider if this issue occurs.
- It may be difficult for my service provider to provide immediate support during an emergency or crisis. A list of local support, emergency, and crisis services may be provided to me at time of intake and/or my service provider and I may develop a plan for emergencies or crises.

I understand that there are benefits of telemedicine, including, but not limited to:

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- Flexibility: I can attend therapy and other services where convenient for me if guidelines outlined in this document are followed.
- Ease of Access and Convenience: I can attend telehealth sessions at a location of my choosing without worrying about traveling, meaning I can schedule less time per session and can attend therapy and other services during inclement weather or illness.

I understand that I have the following rights with respect to telemedicine:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care of treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- I understand that a variety of alternative methods of care may be available to me, and that I may choose one or more of these at any time. These alternatives have been explained to my satisfaction.
- The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my therapy, or another service is generally confidential. However, there are both mandatory and permissive expectations to confidentiality, including but not limited to reporting child, elder and dependent abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I also understand the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
- I understand that I have a right to access my medical information and copies of medical records in accordance with West Virginia law.

I understand and agree to abide by the requirements to participate in Telehealth services outlined below:

- I will need to be in a quiet and private space, relatively free from distractions.
- Other people cannot hear my conversation or see my screen during sessions.
- I cannot be driving or riding in a vehicle.
- Recording the session using video or audio is not permitted unless I have asked my service provider and obtained permission in advance.
- I will provide current and accurate demographic information and emergency contacts in the event of an emergency or loss of connection.
- I will need to inform my service provider if I am not in my usual location before starting any telehealth session.
- Use of headphones is recommended but not mandatory.

By signing this form, I certify:

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- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefit(s) of telehealth services.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Client Signature Date

_____

Client Name (print)

Tucker Day Report
Behavioral Health Services
213 First St.
Parsons, WV 26286
304-478-2833

CONSENT TO RECORD GROUP SESSION

I hereby give permission to Tucker Day Report to record our meeting(s) on audio/video. I understand that the purpose of this recording is to ensure treatment compliance and to maintain the safety of staff and group participants. I understand that listeners and viewers of the recording may include all Tucker Day Report Staff and the WV Division of Corrections and Rehabilitation – Parole Services.

My signature below indicates that I give Tucker Day Report permission to audiotape/videotape our meetings and that I understand the following:

1. I can revoke my permission for you to record me at any time, with the understanding that if I choose to do so, I will need to reenroll with an alternative provider.

2. The contents of the recorded sessions are confidential, and the information will not be shared outside of the perimeters listed above.

3. The recordings will be stored in a secure location.

4. The recordings will be erased after they have served their professional purpose.

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Limits of Confidentiality

Staff are bound by confidentiality within the Tucker Day Report (TDR) treatment team(s). Contents of individual assessment and psychotherapy sessions are considered confidential, but some exceptions do exist. Treatment staff will strive to maintain confidentiality in group counseling, psychoeducational groups, and all other treatment programming delivered in a group setting. However, because treatment staff cannot control what is said by others, confidentiality cannot be guaranteed. Confidentiality is not absolute, and the following exceptions apply:

Public Safety
If you have been referred by a criminal justice or government agency or officer, feedback (treatment recommendations, prognosis, compliance, and progress) will be regularly reported to this referral source. It is expected that TDR Staff and the referral source will communicate the same information to the Court as well.

Duty to Protect
When a client discloses intentions to harm themselves or another person(s), staff may be compelled to intervene to prevent the harm. Many things may be done in this effort, including but not limited to: warn the intended victim, inform legal authorities, or refer for hospitalization.

Abuse of Children and Vulnerable Adults
Staff are mandatory reporters of abuse and are statutorily required to report their reasonable suspicion of abuse to appropriate legal authorities, including the State Police and/or social services.

Prenatal Exposure to Controlled Substances
Prenatal exposure to controlled substances that is potentially harmful to the unborn child is required to be reported to social services/legal authorities.

Court Orders
Medical records may be subpoenaed by the Court. In this case staff will make every effort to discuss the request from the Court with the client. However, staff will always respond to the Court's subpoena.

Reimbursement
Insurance companies and third-party payers, including government agencies, may request

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information regarding services given to clients. Information includes but is not limited to: types of service, treatment plan, diagnosis, progress in therapy, description of impairment, case notes, and summaries. The same information may be provided to a billing company and may be used in the pursuit of a just debt.

Minors/Guardianship
Legal guardians of non-emancipated minor clients have the right to access the client's records.

I agree to the above limits of confidentiality and understand their meaning and ramifications.

_____ _____
Client Signature **Date**

_____ _____
Legal Guardian (if under 18 yrs. of age) **Date**

_____ _____
Witnessing Staff **Date**

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Teresa Kincaid, *Registered Nurse*
Brittany Mitchell, *Peer Recovery Coach*
Jessica James, *Peer Recovery Coach*
Travis Barnhouse, *Officer*
Dominique Meadows, *Case Manager*

CONFIDENTIALITY AGREEMENT FOR DAY REPORT CLIENTS

I, _____, the undersigned, hereby agree to the premise that all clients are obligated to hold all client information of the Tucker Day Report in confidence for both legal and moral reasons. Under no circumstances shall any information pertaining to another Day Report client be discussed with anyone outside of the Day Report.

I AGREE THAT I WILL NOT:

- Discuss any client or any information pertaining to another client with anyone, including my own family.
- Discuss any client or any information pertaining to another client in any place where it may be directly overheard by anyone, especially other clients.
- Mention any client's name or admit, directly or indirectly that a person named is a client.
- Describe any behavior, which I have observed or learned through my participation at the Day Report.
- Contact any individual or agency outside of the Day Report to get personal information about another Day Report Client.
- Record any encounters that occur while on Day Report property (buildings, vehicles, etc.), this includes, but is not limited to: conversations between myself, staff and/or other clients, conversations not involving myself that I may overhear, regular daily interactions with staff, groups, therapy sessions, Telehealth, BrainPaint, Peer Recovery sessions, etc.

I understand and agree that all information obtained through my contacts with other clients must be kept in confidence. Furthermore, I understand that any violation of confidentiality may result in disciplinary sanctions or termination of my participation in the Day Report Center.

Client Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Title: _____

Tucker County Community Corrections

(Tucker Day Report)

Dustin Luzier, *Director*
Amy Cummings, *Behavioral Health Director*
213 First Street, Parsons, WV 26287
Phone: 304-478-2833
Fax: 304-478-4473

Alexis Baker, *Project Coordinator*
Teresa Kincaid, *Registered Nurse*
Brittany Mitchell, *Peer Recovery Coach*
Jessica James, *Peer Recovery Coach*
Travis Barnhouse, *Officer*
Dominique Meadows, *Case Manager*

Behavioral Health Services

Statement of Patient Rights

1. A patient receiving care or treatment under section 7 of the act (71 P. S. § 1690.107) shall retain civil rights and liberties except as provided by statute. No patient may be deprived of a civil right solely by reason of treatment.

2. Patients have the right to be treated with dignity and respect, regardless of your race, religion, gender, ethnicity, age, disability, or source of payment.

3. HBH may not discriminate in the provision of services on the basis of age, race, creed, sex, ethnicity, color, national origin, marital status, sexual orientation, handicap or religion.

4. Patients have the right to inspect their own records. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the patient if the director determines that the information may be detrimental if presented to the patient. Reasons for removing sections shall be documented in the record.

5. Patients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records.

6. Patients have the right to appeal a decision limiting access to their records to the director.

7. Patients have the right to submit rebuttal data or memoranda to their own records.

8. Patients have the right to know their therapist's credentials, experience, and professional background.

9. Patients have the right to ask your therapist about their outcome rates.

10. Patients have a right to receive a comprehensive and thorough psychosocial evaluation/history.

11. Patients have a right to a diagnosis and prognosis at as early a stage of therapy as possible.

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12. Patients have the right to a written treatment plan that should be created together with the therapist and utilized, with necessary amendments and changes, throughout the course of therapy.

13. Patients have a right to understand the costs of individual therapy sessions and projected costs of total therapy sessions upon request, before committing to a course of therapy.

14. Patients have the right to a beginning, middle and an end to therapy. If protracted or ongoing therapy is required, then the patient has the right to understand why their diagnosis might warrant this course of action.

15. Patients have the right to have their own treatment responsibilities explained thoroughly as well as understand the therapist's responsibilities to the therapy process and to the patient. This includes the responsibility of the therapist to try a different course of treatment and/or refer patients to another therapist if therapy is ineffective after a reasonable period of time.

16. Patients have the right to complete confidentiality as provided for by state and federal laws and regulations.

17. Patients have the right to timely access to care.

18. Patients have the right to know their treatment options.

19. Patients have the right to information about clinical guidelines used in their care.

20. Patients have the right to give input regarding patient rights and responsibilities.

21. Patients have the right to know about advocacy groups and prevention services.

22. Patients have the right to freely file a complaint or appeal and to learn how to do so.

23. Patients have the right to list provider preferences.

24. Patients have the right to refuse any treatment or medication.

Statement of Patient Responsibilities

Tucker County Community Corrections

(Tucker Day Report)

Dustin Luzier, *Director*
Amy Cummings, *Behavioral Health Director*
213 First Street, Parsons, WV 26287
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1. Patients have the responsibility to treat those providing care with dignity and respect.

2. Patients have the responsibility to provide the information needed for their care.

3. Patients have the responsibility to ask questions about their care.

4. Patients have the responsibility to follow their mutually agreed upon treatment plan.

5. Patients have the responsibility to tell their provider and primary care physician about medications they take and changes to medications.

6. Patients have the responsibility to keep their appointments and call their provider as soon as possible if you need to cancel or reschedule.

7. Patients have the responsibility to let their provider know if their treatment plan isn't working.

8. Patients have the responsibility to let you provider know if you have trouble paying fees.

9. Patients have the responsibility to report fraud and abuse.

10. Patients have the responsibility to openly discuss concerns about the quality of care they receive.

By signing I am agreeing that I have read, understood, and agree to the items contained in this document.

Signature of Patient or Parent if Minor: _____ Date: _____

Relationship to Patient: _____

Tucker County Community Corrections

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Tucker Day Report Hours of Operation

8AM – 4PM or by appointment

Tucker Day Report is not a 24-hour agency. In case of emergency, please dial 9-1-1 or refer to the emergency contact information listed below.

Emergency Contact Information

In case of crisis after hours or on weekends, below is a list of crisis information, crisis services and/or referral services in the area:

DAVIS MEMORIAL HOSPITAL 304-636-3300

APPALACHIAN COMMUNITY HEALTH 304-636-3232

WILLIAM R. SHARPE JR. HOSPITAL 304-269-1210

Cancellation and No-Show Policy

Client agrees to keep all appointments with Tucker Day Report. If unable to keep an appointment, it is requested that a notification be given at least 24 hours in advance. If you fail to keep regularly scheduled appointments, it may result in one or more of the following actions: your time slot may be forfeited, you may be unable to successfully complete the service and may be required to restart the service, or services may be placed on hold and you may be placed in a non-compliance group where completion will be required prior to resuming services.

By signing I am agreeing that I have read, understood, and agree to the items contained in this document.

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Tucker County Community Corrections

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Tucker Day Report (TDR) Notice of Privacy Practice ("Notice"):

1. It tells me how TDR will use my health information for the purposes of my treatment, payment for my treatment, and TDR's health care operations.
2. The Notice explains in more detail how TDR may use and share my health information for other than treatment, payment, and health care operations.
3. TDR will also use and share my health information as required/permitted by law.

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____

Tucker Day Report Center

213 First Street
Parsons, WV 26287
(304) 478 - 2833
Fax: (304) 478 - 4473

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	◦ You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. ◦ We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	◦ You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. ◦ We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	◦ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. ◦ We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	◦ You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. ◦ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	◦ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. ◦ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	◦ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	◦ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ◦ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	◦ You can complain if you feel we have violated your rights by contacting us using the information on page 1. ◦ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** ◦ We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	◦ We can share health information about you for certain situations such as: ◦ Preventing disease ◦ Helping with product recalls ◦ Reporting adverse reactions to medications ◦ Reporting suspected abuse, neglect, or domestic violence ◦ Preventing or reducing a serious threat to anyone's health or safety
Do research	◦ We can use or share your information for health research.
Comply with the law	◦ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	◦ We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	◦ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	◦ We can use or share health information about you: ◦ For workers' compensation claims ◦ For law enforcement purposes or with a law enforcement official ◦ With health oversight agencies for activities authorized by law ◦ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	◦ We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We will not share your Substance Abuse treatment records without a signed consent.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

November 1, 2018

This Notice of Privacy Practices applies to the following organizations.

Tucker Day Report
Behavioral Health Services
213 First St.
Parsons, WV 26287
(304) 478-2833

Consent for Disclosure of Confidential Substance Abuse and/or Mental Health Information

Client Name: _____ **DOB:** _____

I. Disclosure

I hereby authorize and consent to communication between and disclosure among Tucker Day Report (TDR) staff members and the WV Division of Corrections and Rehabilitation – Parole Services, of my supervising jurisdiction. This includes communication with and disclosure to one another among the TDR staff of any and all records, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program(s), and any other treatment related information while I am participating in TDR programs.

I understand that the purpose and need for this disclosure is to inform referring agencies of my compliance and progress in accordance with TDR. Disclosure of this confidential information may be made only as necessary for and pertinent to status reports, hearings, and/or reports concerning my participation in treatment at TDR and my status as a participant in the criminal justice system.

The information as described above may be disclosed verbally, electronically, or via hard copy.

II. Substance Abuse Information

I understand that my substance use disorder records are protected under Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. pts 160 & 164 and cannot be disclosed without any written consent otherwise provided for by the regulations.

III. Additional Rights and Acknowledgements

I understand that:

1. This consent will expire within one year from signature date unless a different date of expiration is specified here: _____
2. I understand that I can revoke this authorization at any time except for information already disclosed under this Authorization. I therefore pledge that this consent will remain in effect and will not be revoked by me until there has been a formal and effective termination of my involvement with TDR and/or parole services.
3. Should I choose to revoke this authorization, the revocation must be submitted in writing, signed, and dated.

4. I understand that authorizing the use or disclosure of this information is voluntary and treatment, payment, or other benefits may not be conditioned on the execution of this authorization. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal privacy standards.
5. I understand the nature of this Authorization and freely give consent.

By signing this form, I agree to the following:

I have received this electronic copy of the Consent for Disclosure of Confidential Substance Abuse and/ or Mental Health Information form. I fully understand my rights and I am signing this consent voluntarily. I understand a paper copy of this consent will be mailed to me, upon request.

_____ _____

Client Signature Date

Tucker Day Report
Behavioral Health Services
213 First St.
Parsons, WV 26287
(304) 478-2833

Consent for Disclosure of Confidential Substance Abuse and/or Mental Health Information

Client Name: _____ DOB:_____

I. Disclosure

I hereby authorize and consent to communication between and disclosure among Tucker Day Report (TDR) staff members and the Horizons Behavioral Health, PLLC staff (HBH) staff members. This includes communication with and disclosure to one another among the TDR staff of any and all records, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program(s), and any other treatment related information while I am participating in TDR programs.

I understand that the purpose and need for this disclosure is for coordination of treatment and care, and to ensure compliance and progress in accordance with TDR. Disclosure of this confidential information may be made only as necessary for and pertinent to status reports, hearings, and/or reports concerning my participation in treatment at TDR and my status as a participant in Tucker Day Report.

The information as described above may be disclosed verbally, electronically, or via hard copy.

II. Substance Abuse Information

I understand that my substance use disorder records are protected under Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. pts 160 & 164 and cannot be disclosed without any written consent otherwise provided for by the regulations.

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2. I understand that I can revoke this authorization at any time except for information already disclosed under this Authorization. I therefore pledge that this consent will remain in effect and will not be revoked by me until there has been a formal and effective termination of my involvement with TDR and/or Horizons Behavioral Health, PLLC.
3. Should I choose to revoke this authorization, the revocation must be submitted in writing, signed, and dated.

4. I understand that authorizing the use or disclosure of this information is voluntary and treatment, payment, or other benefits may not be conditioned on the execution of this authorization. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal privacy standards.
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_____ _____

Client Signature Date