Eliot

ELIOT COMMUNITY HUMAN SERVICES, INC.

Registration Form

Demographic Information

Client Name: _____ Date: _____

Parent/Guardian: _____

Please note any custody or guardianship orders: _____

_____

Allergies: ☐ None Known _____

Date of Birth: _____ Gender: ___Male __Female ___Transgender ___Other

Marital Status: ____Single ____Separate ____Divorced ____Widowed

Preferred Laguage: _____

Race: ____ American Indian or Alaska Native ____ Asian ____ Black or African American

____ Native Hawaiian or Other Pacific Islander ____ White ____ Declined to Specify

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Declined to Specify

Social Security #: _____

Insurance + Policy Number: _____

Home Address: _____

City: _____ State: _____ Zipcode: _____

Referred By: _____

Home Phone: _____ *May we identify ourselves and/or leave a message?* ____Yes ____No

Cell Phone: _____ *May we identify ourselves and/or leave a message?* ____Yes ____No

Email: _____ *May we identify ourselves and/or leave a message?* ____Yes ____No

In the event of an emergency whom should we contact?

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

Services Requested

What brings you to Eliot today? ____Suicidal (thoughts of self harming)

_____

_____

_____

What other services are you interested in?:

_____ Peer Services _____ Individual Therapy _____ Coping Skills Training

_____ Recovery Coaching _____ Family Support Services

_____ Group Therapy _____ Psychiatry/Med. Management

Eliot

Eliot Community Human Services, Inc.
Community Behavioral Health Clinic (CBHC) Orientation

CBHC Orientation Signoff

I have been provided written information related to the following areas to orient me to the policies and procedures of Eliot's CBHC and to provide necessary information related to Privacy and Patient Rights:

- CBHC Orientation
  - General Expectations
  - Lack of Engagement
  - Fee/Cost
  - Medical Care
  - HIV, Tobacco, and Tuberculosis Assessment, Counseling and Education
  - Complaints/Grievances
  - CBHC Availability
  - Discharge From Services
- Notice of Patient Rights M.G.L, Ch. 111, Sec. 70E
- HIPAA Privacy Notice

I understand and agree with the information provided to me and have had the opportunity to ask questions.

Please initial the following to indicate your agreement with the additional areas outlined in the Agreement.

Initial	Additional Areas
	As a patient of Eliot Community Human Services, Inc. (Eliot), I freely and voluntarily agree to accept this treatment contract regarding the prescribing of medications as outlined in the **"Medication Treatment Agreement"** section of this agreement in addition to the standing service agreement that applies to all services. I have had the opportunity to ask questions.
	I authorize Eliot Community Human Services (Eliot) to send text messages to my cell phone to provide information to confirm upcoming appointments as outlined in the **"Text Messaging Appointment Confirmation Consent"** section of this agreement. I have had the opportunity to ask questions.
	I authorize Eliot Community Human Services (Eliot) to provide services via Telehealth technology as outlined in the **"Telehealth"** section of this agreement. I have had the opportunity to ask questions.
	I have read, understand and agree to the information outlined in the **"Fee Agreement"** section of this agreement. I have had the opportunity to ask questions.

Client/Guardian Signature: _____ Date: _____

Eliot

ELIOT COMMUNITY HUMAN SERVICES, INC.

Health History Questionnaire

All questions contained in the questionnaire are strictly confidential and will become part of your medical record

Name (Last, First, MI) _____ Male Female DOB: _____

Previous or referring Doctor: _____ Date of last Physical: _____

Name of Primary Care Doctor:

Personal Health History

List any medical problems that other Doctors have diagnosed:

Hospitalizations:

Year:	Reason:	Hospital:

List you prescribed medications and over the counter medications, such as vitamins and inhalers:

Medication Name	Strength	Frequency Taken

Allergies to medications:

Medication	Reaction You Had

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID (MASSHEALTH)

PERMISSION TO GET AND SHARE INFORMATION IN THE MASSHEALTH CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) SYSTEM

Name of MassHealth member (Member) _____

Name of behavioral-health assessor (Assessor) _____

Name of provider organization (Provider) _____

Provider address _____

_____ (Member) is under the age of 21 and is receiving a behavioral health assessment.

What is the CANS

Behavioral-health providers (providers) use a tool called the Child and Adolescent Needs and Strengths (CANS) to collect behavioral health clinical information about members under 21. For members who are in ongoing treatment, a provider will regularly update the CANS at least every 90 days.

The information collected using the CANS tool (CANS Information) helps providers to do a number of things, such as:

- decide what behavioral health services a member may need
- check over time that behavioral health services are helping the member

Why MassHealth Wants to Obtain and Share CANS Information

MassHealth has a computer system that a provider can use to enter CANS Information each time a behavioral health assessment is done or updated. MassHealth wants to use the system to access CANS Information and share it with providers and MassHealth managed care entities (organizations that manage and pay for a member's care) so that such parties can work together to make sure that the behavioral health services offered to the member meet the member's needs. Sharing CANS Information through the system will also help better inform the member's providers of the member's medical history and reduce the overall amount of information that such providers must collect from the member, as further described below.

If you give your permission, the Provider noted above will enter any CANS Information that it collects about the Member into the MassHealth system. Through this system, MassHealth will be able to access such information and make it available to the Provider for future access. MassHealth will also use the system to give the Provider access to any CANS Information entered by the Member's other providers. This will allow the Provider to update the Member's CANS Information when needed, rather than redoing the whole CANS again. If you agree, MassHealth will also use the system to give the Member's other

What Is CANS Consent? Why Is Consent So Important?

Your child's provider will ask for your permission, or consent, to enter the CANS ratings and comments into MassHealth's secure online database. This means you are allowing MassHealth and your child's managed-care plan to see your child's CANS records. Your consent **does not** allow other state agencies, such as the Department of Youth Services or Department of Children and Families, to see your child's CANS record. Access to your CANS record is restricted and protected under state and federal privacy laws. To protect your child's privacy MassHealth keeps tight control over who has access to the database.

What Are the Benefits of Giving Consent?

Giving permission for the provider to enter your child's CANS information into the database allows him/her to print a CANS report for you at any point in your child's treatment. You or your provider can also send or bring these reports to other providers who work with your child. This helps everyone to be "on the same page" for your child, and may save you from having to answer the same questions for different providers.

Updating the CANS in the database is easy for your provider. He or she can simply edit the CANS that was done last time. In the future we expect to have a report that your provider will be able to print out to show how your child has made progress.

Finally, MassHealth uses the CANS to understand how its services are helping families. Having this information allows MassHealth to improve services in ways that can help your child and others in the future.

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* MassHealth offers several types of behavioral health services for children and youth under age 21. Certain services involve complete assessment and coordination of care when the child is involved in other services. Known as "Hub Services," these include Intensive Care Coordination, In-Home Therapy, and Outpatient Therapy. Some children may be involved in more than one Hub Service. As a MassHealth provider required to use the form, each Hub Service provider must complete the CANS and update it every 90 days.

Another set of services include Family Support and Training (Family Partners), In-Home Behavioral Health Services and Therapeutic Mentors. They are "Hub-Dependent Services," meaning they need a referral from a Hub Service. Providers of these services do not need to complete the CANS but should review the CANS done in the Hub Service.

You should get copies of your child's CANS from his or her provider to share with other providers who work with your family.

providers with permission access to the CANS Information entered by the Provider in the CANS system, so they will understand the Member's history and may not need to ask the Member to repeat as much information. Your permission will also allow MassHealth to use the system to give a MassHealth managed-care entity in which the Member is enrolled access to CANS Information collected by the Provider.

Your Permission

By signing below, you give permission for the Provider listed above to:

- enter all of the CANS Information about the Member that it collects into the MassHealth system
- view and copy any CANS Information about the Member that other providers have entered into the MassHealth CANS system

By signing below, you also give permission for MassHealth to use the system to share CANS Information collected by the Provider with:

- the Provider noted on the first page of this form
- the MassHealth managed-care entity in which the Member is enrolled at the time that the CANS is entered into the MassHealth CANS system
- other providers for whom you have given permission

Things You Should Know

Neither MassHealth nor the Provider may condition treatment, payment, enrollment or eligibility for benefits on whether you sign this form or whether you decide to take back the permission in the future.

If you give your permission to the activities noted above, the Provider will enter CANS Information about the Member into the MassHealth system, and MassHealth will access such information and share it with the Provider, other providers for whom permission is given and the Member's managed-care entity. Your permission will also allow MassHealth to give the Provider access to CANS Information entered into the system by the Member's other providers. **Note that even if you do not provide your permission, MassHealth and the Provider may still use or disclose CANS Information about the Member as required or permitted by law.**

After CANS Information is shared through the MassHealth system, the organization that shared the information will no longer be able to control how it is used or disclosed. The privacy laws covering CANS Information may be different when MassHealth, providers, or managed care entities hold the information, but each such organization must follow the privacy laws that apply to it when using or disclosing the information.

You may put a permission end date on this form below. If you do not, the permission ends one year from when you sign this form.

You may cancel this permission at any time in writing. The cancellation will prevent the Provider and MassHealth from using the MassHealth system to share CANS Information that is collected after you cancel your permission. Information that has already been made available to MassHealth, managed care entities, the Provider or other authorized providers through the MassHealth system prior to receipt of your cancellation cannot be taken back.

The written cancellation must:

- say who the Member is
- give the Member's birth date
- say who you are
- say if you are the Member, the Member's custodial parent, or explain why you can act for the Member
- say that you are cancelling your permission to enter and share CANS Information online

You must give the written cancellation to the Provider at the address noted on the first page of this form. The Provider must then notify MassHealth by emailing a scanned copy of the written cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Your Signature

By signing this permission form, you are giving permission for the uses and disclosures of CANS Information about the Member as noted above. You are also saying: that you have read the whole form and signed it willingly; and that you have the right to get a signed copy of the form.

_____
Printed name of person signing permission

_____
Signature of person signing permission

_____
Date of signing (date permission starts)

_____
Date permission ends (If no date is written on this line, permission will end one year from the date of signing.)

Please check the line below saying why you can sign this permission under law.

_____ I am the Member. I am 18 years old or older. If I am not 18 years old or older, I can give my permission for other reasons under law.

_____ I am the Member's custodial parent.

_____ I am able to act for the member to give permission to give out medical information. I have attached a legal document showing why I can do this.

<u>Reminder to Provider</u>: A signed copy of this form must be given to the Member or caregiver. If the Member or caregiver later cancels this consent, you must e-mail a scanned copy of the cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Authorization to Release Information Within Eliot for Programs Subject to SAMHSA Part 2 Regulations

Name:_____ DOB:_____
Print *MM/DD/YYYY*

Address:_____
Street *City* *State* *Zip*

By signing this form, I hereby grant Eliot Community Human Services, Inc. ("Eliot") permission to release my personal and health information related to Eliot's programs covered by the federal SAMHSA regulations in 42 CFR Part 2 ("Part 2") to all other Eliot programs which may seek to provide or coordinate services for me (whether or not the programs are covered by Part 2). This permission encompasses all forms of my information/records related to Eliot Part 2 programs for all dates of service, including past, present, and future dates.

The information is needed for my care and service coordination. I understand that if I do not sign this form, I will need to sign a separate authorization form in the future to release my personal and health information under Eliot's Part 2 programs to another Eliot program.

I have read and understood the following:

1. I understand that my records are protected under federal and state laws and cannot be disclosed without my written authorization except as provided by law. By signing below, the record of my care will be released as set out above. Once my information has been released to another Eliot program, information identifying me as having or having had a substance use disorder either directly, by reference to publicly identifiable information, or through verification of such identification by another person may not be re-disclosed outside of Eliot unless I expressly permit it, or as otherwise permitted by the Part 2 regulations.

2. I understand that I may refuse to sign this authorization, and any refusal to sign will not affect my ability to receive treatment from Eliot, except where: (i) my refusal may limit Eliot's ability to provide safe and effective care; (ii) I am receiving research-related treatment; or (iii) I am receiving treatment solely for the purpose of creating information for release to another person or organization. If any of these exceptions apply, my refusal to sign this authorization may result in my not obtaining treatment from Eliot.

3. Having read or having had read to me and understood this form, I release Eliot from any liability arising from release of this information, provided the information is released in accordance with applicable law.

4. I understand that I may withdraw this authorization at any time and prevent further release of my personal and health information related to Eliot's Part 2 programs, except to the extent Eliot has already released my information. To withdraw this authorization, I must give written notification to: Privacy Officer, Eliot Community Human Services, _____.
5. This authorization to release information will become void upon my death.

_____ _____

Signature of client of Authorized Legal representative Date

PRINT NAME:_____

Eliot

Consent for treatment with Buprenorphine/Naloxone
Information adapted from PCSS for MAT Training and BMC's consent for treatment

Buprenorphine/Naloxone (Suboxone) is an FDA approved medication for treatment in individuals with opioid use disorder. Buprenorphine is classified as an opioid agonist, and Naloxone is classified as an opioid antagonist. In combination, buprenorphine/naloxone can be used for both detoxification of a substance and maintenance therapy. Maintenance therapy with buprenorphine/naloxone can continue as long as medically necessary. Other treatment options for opioid use disorder include methadone, naltrexone, therapy and support groups.

If you are dependent on opioids, you should be experiencing as much withdrawal as possible when you arrive for your initial induction dose of buprenorphine/naloxone. If you are not in withdrawal, buprenorphine can cause rapid, severe opioid withdrawal. For this reason, the initial dose of buprenorphine/naloxone will be taken at the clinic under the supervision of medical professionals. You should not drive, or operate heavy machinery until you know how buprenorphine/naloxone affects you.

Regular buprenorphine use will result in opioid dependence; as such, buprenorphine should not be abruptly discontinued as it will result in symptoms of withdrawal including but not limited to: nausea, diarrhea, muscle aches, malaise, and stomach cramps. In order to avoid these symptoms, buprenorphine should be tapered slowly over a few weeks under the guidance of your healthcare provider in the event you wish to discontinue buprenorphine use..

It may take several days to transition from the opioid you have been using to buprenorphine/naloxone. During this period of transition, any use of other opioids can cause an increase in symptoms. After stabilization on buprenorphine, the use of other opioids will lose their effect. Any attempt to override the buprenorphine by taking higher doses of alternative opioids during this time could result in death due to opioid overdose.

Combining buprenorphine with alcohol, benzodiazepines or other sedating medication is dangerous and can lead to respiratory depression, coma, and death. You should not take any new medications without discussing with your healthcare provider first. (Benzodiazepines include Klonopin, Xanax, Ativan, Valium and Librium.) If you are currently taking any of these medications, or drinking high quantities of alcohol regularly, you may be referred to a higher level of care prior to beginning treatment with buprenorphine/naloxone.

The buprenorphine you will be taking is a combination formulation, meaning it is a combination of buprenorphine and a short-acting opiate blocker/antagonist (naloxone). The ratio of this combination is a

4:1 ratio, (4mg of Buprenorphine to 1mg of Naloxone). If Buprenorphine/Naloxone were to be dissolved and injected by someone using heroin or another opioid, it would induce severe opioid withdrawal.

In order for the medication to be fully absorbed, Buprenorphine/Naloxone tablets must be held under the tongue until they are fully dissolved. Buprenorphine/Naloxone film strips must be fully dissolved under the tongue or dissolved on the inside of the cheek. It is important to not swallow the Buprenorphine/Naloxone tablets, swallowing these tablets with decrease the ability for the medication to be absorbed into the system.

I have read and understand the above details about Buprenorphine/Naloxone and the treatment that follows. I have had my questions about Buprenorphine/Naloxone treatment answered. I fully agree to be treated at Eliot Community Human Services OBAT clinic with Buprenorphine/Naloxone for my opioid use disorder.

Printed Name	**Signature**	**Date**

AUTHORIZATION FOR THE USE OR DISCLOSURE OF INFORMATION

Eliot Community Human Services Inc.

CLIENT NAME: _____ DATE OF BIRTH: _____ DATE ___ / ___ / _____

By signing this Authorization for the Use or Disclosure of Information, I authorize Eliot Community Human Services, Inc. to receive and release information from or to the person or organization named below, either verbally or in writing:

Organization/Individual: _____

Address: _____ (Fax#) _____ (Phone) _____

For requests related to alcohol or drug abuse records, is the recipient a treating provider or third-party payer? ☐ Yes ☐ No

Eliot Program: Eliot Tri City CBHC Attention: _____

Address 95 Pleasant St, Lynn MA (Fax#) 781-592-0581 (Phone) 781-581-4000

INFORMATION TO BE USED/DISCLOSED

☐ The entire clinical/medical record (all information) ☐ Only services from _____ to _____ ☐ All information in my clinical/medical record related to services provided to me in the following program(s): _____	☐ All information in my clinical/medical record related to services provided to me by the following provider/staff : _____ ☐ Other (describe as specifically as possible): _____

INFORMATION REQUIRING SPECIFIC AUTHORIZATION

Please indicate the **specific categories of information** you agree to release by checking and initialing the boxes below:

☐ _____ **HIV/AIDS** (specify dates _____)
☐ _____ **Sexually transmitted diseases**
☐ _____ **Family planning services**
☐ _____ **Alcohol or Drug Abuse** (protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WITH WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2)
☐ _____ **Other(s):** _____ (please specify)

☐ _____ **Sexual Assault**
☐ _____ **Domestic Violence treatment/counseling**
☐ _____ **Psychotherapy notes**

PURPOSE(S) OF USE/DISCLOSURE

☐ Continuing care/treatment	☐ My personal records	☐ Coordination of care
☐ Legal matter		☐ Insurance (such as health, life, or disability insurance)

I wish to have the information released in the following format(s): Verbal____ Written via Mail____ Fax____ Electronic____

☐ Verbally **and/or** ☐ Paper Document via: ☐ Mail ☐ Fax ☐ Electronic Format (when possible)

AUTHORIZATION

I have read and understand the terms of this Authorization and agree that:

1. With my signature, the protected health information ("PHI") specified above will be released to the recipient designated above.
2. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
3. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Eliot except when: (i) my refusal may limit Eliot's ability to provide safe and effective care; (ii) I am receiving research-related treatment, or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these excepts apply, my refusal to sign an authorization may result in my not obtaining treatment from Eliot.
4. I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by Eliot prior to receipt of my written notice of revocation. I may revoke this authorization by writing to Eliot Community Human Services, Inc., Attn: Compliance Officer, 125 Hartwell Ave, Lexington MA 02420.

This authorization will automatically expire upon termination of Eliot services, unless otherwise indicated here: _____

_____ _____
Signature of Client or Legal Representative **Relationship if signed by Legal Representative**

_____ _____
Print Name **Date**

AUTHORIZATION FOR THE USE OR DISCLOSURE OF INFORMATION

Eliot Community Human Services Inc.

CLIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE** ___ / ___ / ____

By signing this Authorization for the Use or Disclosure of Information, I authorize Eliot Community Human Services, Inc. to receive and release information from or to the person or organization named below, either verbally or in writing:

Organization/Individual: _____

Address: _____ (Fax#) _____ (Phone) _____

For requests related to alcohol or drug abuse records, is the recipient a treating provider or third-party payer? ☐ Yes ☐ No

Eliot Program: Eliot Tri City CBHC Attention: _____

Address 95 Pleasant St, Lynn MA (Fax#) 781-592-0581 (Phone) 781-581-4000

INFORMATION TO BE USED/DISCLOSED

☐ The entire clinical/medical record (all information) ☐ Only services from_____to _____ ☐ All information in my clinical/medical record related to services provided to me in the following program(s):_____	☐ All information in my clinical/medical record related to services provided to me by the following provider/staff : _____ ☐ Other (describe as specifically as possible): _____

INFORMATION REQUIRING SPECIFIC AUTHORIZATION

Please indicate the specific categories of information you agree to release by checking and initialing the boxes below:

☐ _____ **HIV/AIDS** (specify dates_____)
☐ _____ **Sexually transmitted diseases**
☐ _____ **Family planning services**
☐ _____ **Alcohol or Drug Abuse** (protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WITH WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2)
☐ _____ **Other(s):** _____(please specify)
☐ _____ **Sexual Assault**
☐ _____ **Domestic Violence treatment/counseling**
☐ _____ **Psychotherapy notes**

PURPOSE(S) OF USE/DISCLOSURE

☐ Continuing care/treatment	☐ My personal records	☐ Coordination of care
☐ Legal matter		☐ Insurance (such as health, life, or disability insurance)

I wish to have the information released in the following format(s): Verbal____Written via Mail____Fax____Electronic____

☐ Verbally **and/or** ☐ Paper Document via: ☐ Mail ☐ Fax ☐ Electronic Format (when possible)

AUTHORIZATION

I have read and understand the terms of this Authorization and agree that:

1. With my signature, the protected health information ("PHI") specified above will be released to the recipient designated above.
2. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
3. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Eliot except when: (i) my refusal may limit Eliot's ability to provide safe and effective care; (ii) I am receiving research-related treatment, or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these excepts apply, my refusal to sign an authorization may result in my not obtaining treatment from Eliot.
4. I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by Eliot prior to receipt of my written notice of revocation. I may revoke this authorization by writing to Eliot Community Human Services, Inc., Attn: Compliance Officer, 125 Hartwell Ave, Lexington MA 02420.

*This authorization will automatically expire upon termination of Eliot services, unless otherwise indicated here:*_____

_____ _____

Signature of Client or Legal Representative **Relationship if signed by Legal Representative**

_____ _____

Print Name **Date**

Eliot

Eliot Community Human Services, Inc.
Community Behavioral Health Clinic (CBHC) Orientation

Eliot Community Human Services, Inc. (Eliot) is committed to providing a continuum of innovative and high-quality services, which are client centered, flexible, easily accessible and responsive to client needs through our Community Behavioral Health Clinic (CBHC). Our Substance Abuse services include prevention, evaluation, crisis intervention, treatment and consultation to adolescents, adults and elders with substance abuse struggles.

The CBHC will not deny services or otherwise discriminate in the delivery of services to any person who otherwise meets the eligibility criteria of the program based on race, color, gender or gender identity, creed, ethnic and/or national origin, religion, age, sexual orientation, ancestry, language, physical or mental disability, housing or financial status. In accordance with both Section 504 of the Rehabilitation Act and the Americans with Disabilities Act, Eliot Community Human Services is committed to providing accessible services and making reasonable accommodations for individuals with disabilities.

Masters level licensed or license eligible Clinicians are skilled to provide a wide range of outpatient counseling services including Substance Abuse Outpatient Counseling (individual, group, couple and family therapies), Psychoeducation, as well as Mental Health services. Psychopharmacology treatment services are also available by our licensed prescribers. For all services, Consent for Treatment is needed.

General Expectations

- I agree to conduct myself in a courteous, respectful manner in the office and by telephone with Eliot staff and other patients in the office. No abusive, threatening, racist, or otherwise inappropriate behavior or violence directed at staff or other clients.
- I agree not to arrive at the office intoxicated or under the influence of drugs or alcohol. If I do, I may be rescheduled at staff's discretion.
    - If I have driven a vehicle while intoxicated to the site, Eliot reserves the right to request my keys to support me with finding a safe way home. If I leave the property under the influence with the intent to operate a vehicle, local police will be contacted.
- I agree not to possess or use alcohol, illegal street drugs, recreational marijuana or medications not prescribed to me on Eliot property.
- I agree to be on time for all scheduled appointments. I understand that if I am late, I may need to be rescheduled at staff's discretion.
- I agree not to deal, steal, or conduct any other illegal or disruptive activities in the Eliot offices or premises. I understand that failure to adhere to this policy may result in termination of services.

- I agree not to smoke or use a vaporizer (e.g. e-cigarettes, e-pipes, etc.) inside of Eliot properties and to only utilize these products in designated smoking areas, when available.
- I agree not to bring weapons or any kind onto Eliot property including, but not limited to, pocket knives, guns, mace and pepper spray.

Medication Treatment Agreement

Whenever medications are utilized in treatment, client(s)/guardian(s) will be informed of all medications prescribed including any possible risks and/or side effects. For medications to be utilized most responsibly and safely, clients and/or guardians are expected to adhere to the following Medication Treatment Agreement. Additional, medication-specific treatment agreements are required for the prescription of other medications, including but not limited to, Buprenorphine/Naloxone and Esketamine:

- I understand that many studies have demonstrated that the most substantial and longest lasting improvements can be achieved in clients engaged in a comprehensive treatment approach rather than with medications alone. To this effect, I understand that medication alone is not sufficient treatment for my condition, and I agree to work with my mental health providers to identify and implement a comprehensive approach to treatment. I agree that consistently engaging in therapy or other services may be a prerequisite to accessing medication services.
- I understand that to have medication safety and effectively prescribed to me, I must meet with my prescriber at regular predetermined intervals and with sufficient time for the meeting to ensure I am able to discuss my experiences, concerns and/or any recent developments with my prescriber. I agree to keep, and be on time to, all my scheduled appointments with the prescriber. I understand that if I am late, my prescriber may not be able to see me. I understand that if I do not keep all scheduled appointments or my appointment needs to be rescheduled due to being late and/or attending appointments under the influence of drugs or alcohol, I may not be eligible to receive medication refills.
    - If I have or anticipate having challenges to making it to scheduled appointments, I understand that I should discuss with my prescriber to identify possible solutions and/or ways to overcome those challenges.
- I agree to notify my prescriber immediately if I am pregnant or intend to get pregnant to discuss treatment options.
- I understand that, while discussing substance abuse and/or overuse of medication is difficult and that relapse is part of recovery, I am expected to inform my prescriber about any struggles with substance abuse or overuse of medications to ensure they are able to assist if the need arises. I understand the importance of discussing this

early in treatment and at times of relapse to ensure I get the help I need and so that my prescriber can make informed decisions regarding my medication.

- I understand that some medications can have dangerous interactions with commonly abused substances and/or other medications.
- I understand that I may be asked to give a blood or urine sample to test for substance use.
- I understand that I may be subject to periodic random pill counts to check that medication is being taken as prescribed.
- I understand that laboratory monitoring is essential for prescribing some medications safely. I agree to independently complete all laboratory monitoring that is recommended by my prescriber and understand that I may not be eligible to receive medication refills until these results are available.
- I understand that if my laboratory monitoring indicates nonadherence with my prescribed medications or use of non-prescribed medications, I may no longer be eligible to receive prescriptions for controlled substances or refills of current prescriptions.
- I understand that serious consequences can arise from people taking medication that is not prescribed to them and agree not to sell, share, trade, or give any of my medication to any another individual.
- I agree to take my medication as prescribed, and to not alter the way I take my medication without first consulting with my prescriber. I will discuss any issues or concerns related to medications with my prescriber. I understand that altering the way I take my medications without consultation can be dangerous and can have serious consequences for my mental and physical health.
- I agree to inform my prescriber regarding all other medications that I am taking from any other physicians, pharmacies or other sources. I will inform my prescriber regarding any additional or new medications prescribed from outside sources and understand the importance of checking with my prescriber prior to taking new medications due to potential contraindications and to ensure my medications and dosages are safe and effective. I understand I must also let my other prescribers know about the medications I receive from Eliot.
- I understand that mixing alcohol or non-prescribed substances with medications can be dangerous and may result in sedation, impaired judgment, respiratory depression, and/or death. I understand that I should not drive or operate heavy machinery until I know how my medication affects me, or if I feel sedated or have any other concerning side effects. I also understand that I may not be eligible to receive prescriptions for certain medications if they are contraindicated with ongoing substance abuse.
- I understand that the medication I receive is my responsibility and that I will keep it in a safe, secure place where unauthorized individuals will not have access. I agree that lost or stolen medication may not be eligible to be replaced or refilled.

- I agree to monitor the need for medication refills and request refills at scheduled appointments as needed and/or during regular office hours and at least 48 hours or 2 business days in advance.
- I understand that controlled substances are generally not eligible to be refilled early.
- I understand that Eliot prescribers do not prescribe medications that are not approved by the FDA or DEA for psychiatric care, including but not limited to medical marijuana.
- I understand that guidelines for treatment strategies and safe and effective prescribing of medications are reviewed and updated regularly at Eliot and incorporate new research and best practice guidelines. I understand that having a previous prescription for a medication is not a guarantee that I will receive a prescription for that medication in the future or on an ongoing basis.
- I understand that all of the prescribers in this program practice according to these guidelines, and that a disagreement about treatment planning is not an indication to be reassigned to a different prescriber.
- I understand that Eliot is committed to providing services to all clients and I agree to inform my prescriber/staff of any changes in my insurance coverage or financial situation that may impact my ability to afford medications.
- I understand that an important part of an effective and comprehensive treatment approach is proper care coordination and therefore agree to provide written authorization to communicate with outside providers for this purpose.
- I understand that additional, medication specific treatment agreements are required for prescription of other medications, including but not limited to, Buprenorphine/Naloxone and/or Esketamine.

Stimulant Medication

- I understand the potential risks and benefits of being prescribed stimulants including, but not limited to, the risk for drug dependence and increased tolerance.
- I understand that I should not stop my medication without first consulting my prescriber due to risk of withdrawal symptoms.
- I understand that testing, medical records, or other documentation may be required prior to receiving a prescription for certain controlled substances (stimulants) prescribed for the treatment of ADHD.
- I understand that if I am prescribed a stimulant medication, I must attend my appointment in order to receive my prescription.
- I understand that ongoing marijuana use/abuse may be a contraindication to receiving a prescription for controlled substances (stimulants) prescribed for the treatment of ADHD.

- I understand that I will receive prescriptions for no more than a 30 day supply of medications at a time. I understand that the prescriber may choose to direct the pharmacy to provide less than a 30 day supply at a time.
- I understand that I will be given the lowest possible dose of medication to control my symptoms.
- I understand that mixing Stimulant medication with other medications can be very dangerous. I understand that should I overuse my prescriptions or abuse other non-prescribed substances, this issue will be addressed through changes in my treatment plan to help me address the issues. If I continue to struggle with ongoing drug use this could be grounds for discontinuation of my Stimulant medication prescription in favor of a safer and/or more effective option.

Benzodiazepines and Nonbenzodiazepine Medication

- I understand the potential risks and benefits of being prescribed a benzodiazepine and/or a nonbenzodiazepine sedative includes the risk for drug dependence and increased tolerance.
- I agree to participate in recommended treatments such as additional non-Benzodiazepine medication trials indicated for my condition as well as therapy, patient education and substance abuse counseling and relapse prevention programs, as provided, to assist me in my treatment.
- I understand that benzodiazepines are indicated for short-term treatment of anxiety, and that the FDA has issued guidelines that strongly advise against the co-prescription of opioids of any kind, including methadone/buprenorphine and benzodiazepines. In this context, I understand that the long-term goal of any benzodiazepines or nonbenzodiazepine medication prescribed will be to slowly taper off and to simultaneously find more sustainable, longer-term solutions for the management of anxiety.
- I understand that I will be given the lowest possible dose of medication to control my symptoms.
- I understand that mixing benzodiazepines or narcotic drugs with other medications, especially Opioids, Buprenorphine, Methadone and other sedating substances including alcohol can be dangerous. I understand that a number of deaths have been reported among persons mixing Opioids or Alcohol with benzodiazepines or nonbenzodiazepine hypnotics.
- I understand that I should not stop my medication without first consulting my prescriber due to risk of withdrawal symptoms which may include, but are not limited to, anxiety, fatigue, vomiting, seizures, diarrhea, coma and death. I understand that if I begin to experience symptoms of withdrawal, I should seek immediate medical attention as these symptoms can become life threatening.

- I understand that if I am prescribed a benzodiazepine and I choose to take more than what is prescribed I am understand the consequences and understand that if withdrawal symptoms were to arise, I would need to go to an emergency room.
- I understand that should I overuse my prescriptions or abuse other non-prescribed substances, this issue will be addressed through changes in my treatment plan. If I continue to struggle with ongoing substance use this could be grounds for discontinuation of my benzodiazepine or nonbenzodiazepine prescription. I understand that it is dangerous to take more of my medication than is prescribed.
- I understand that I will receive prescriptions for no more than a 30 day supply of medications at a time. I understand that the prescriber may choose to direct the pharmacy to provide less than a 30 day supply at a time.
- I understand that if I choose to take more of my benzodiazepine as prescribed I will not receive an early refill and will instead likely receive a benzodiazepine taper to safely manage the possibility of withdrawal symptoms. I understand that if I am not eligible to receive a benzodiazepine taper and I begin to experience withdrawal symptoms, I should seek immediate medical attention.

I understand that if I am not in agreement with any aspect of this agreement, my best recourse is to seek care elsewhere in order to find treatment that is a better match for the care I am seeking.

Lack of Engagement

While Eliot understands that a number of unanticipated issues or events can arise that can cause a person to miss or cancel appointments, efforts will be made to limit missed appointments.

- If you are unable to attend your appointment as scheduled, please contact staff at least 24 hours in advance.
- Cancellations and/or no-shows will be discussed between you and your practitioner to attempt to address/negotiate barriers to attending appointments.
- Lack of engagement may result in discussion and/or notification regarding discharge, as appropriate.

Fee/Cost

- Staff will work with clients on an individualized basis to identify/obtain any necessary information for the purposes of identifying sliding scale options for clients who meet criteria based on income and family size only.
- If insurance information is provided for payment of services, verification of insurance eligibility is required prior to receiving services.

- If insurance information is provided for payment of services, staff will request authorization to bill your insurance company and release any medical information to insurer(s) necessary to process any claims.

Eliot

Eliot Community Human Services, Inc.
Community Behavioral Health Clinic (CBHC) Orientation

Fee Agreement

- I agree to authorize my insurance(s) to pay Eliot Community Human Services for the services I receive. I also authorize the release of any medical information to my insurer(s) that is necessary to process any claims.
- I understand that benefit information is not a guarantee of payment.
- I understand that any secondary insurance may cover all or a portion of my copayment/deductible. If this insurance lapses, I understand that I will be responsible to pay the full amount of copayment/deductibles at the time of my visit.
- I understand that all co-payments and/or fees are due and payable at the time of each visit.
- I understand that if my insurance company does not pay as anticipated, I agree to pay any back balance that may have accumulated. Eliot agrees to reimburse me if there is any overpayment.
- I agree to notify Eliot if my financial situation changes or if there are changes in my insurance coverage.
- I understand that if I do not have insurance, if my insurance lapses and/or terminates, or if I choose not to authorize Eliot to bill my insurance, I will be responsible to pay fees.

Medical Care

Coordination of care with all your providers allows for optimal care. At a minimum Authorization to obtain a copy of your last Physical Exam will be requested. Staff will assist you with obtaining a Primary Health Care Provider if you do not have one.

HIV, Tobacco, and Tuberculosis Assessment, Counseling and Education

If receiving Substance abuse services clinicians will ask if you would like to have HIV assessment which you may decline. Staff will assess tobacco use and offer education and counseling. Tuberculosis (TB) risk may also be assessed and information and counseling offered.

Complaints/Grievances

All clients are provided the following information: Notice of Privacy Practices and Patients' Rights. In any event in which you feel your rights have been violated in relation to privacy practices or in the provision of services including discrimination, or issues with access based on a disability, termination of services or any concerns you have the right to file a complaint. To file a complaint, you may talk with your Primary Clinician or the Program

Director who can assist you with writing your complaint upon your request or you can contact the Compliance Officer directly at:

Eliot Community Human Services, Inc.
125 Hartwell Ave.
Lexington, MA 02420
781-861-0890

You may also file compliance with DPH directly by completing Patient Complaint Form or calling 24 hour complaint line:

1-800-462-5540
Division of Health Care Facility Licensure and Certification
Complaint Intake Unit
99 Chauncy Street
Boston MA 02111
Fax 617-753-8165

For Substance Abuse services

Confidential Complaint Line
Bureau of Substance Abuse Services:
Phone: 617-624-5171
Fax: 617-624-5599

In the event you feel that you or a friend or family member is being physically or emotionally abused or neglected, you may contact the Disabled Persons Protection Commission (DPPC) at 1-800-426-9009 or the Executive Office of Elder Affairs (EOEA) at 1-800-922-2275 or the Department of Children and Families (DCF) hotline at 1-800-792-5200. They will gather information for you and assist you as needed.

CBHC Availability

Both CBHC Locations operate from 8am - 8pm, Monday through Friday and 9am - 5pm on Saturdays and Sundays.

Eliot's CBHCs have a 24-hour response system:

Tri-City: 1-800-988-1111
North Essex: 1-888-769-5201

Text Messaging Appointment Confirmation Consent

I authorize Eliot Community Human Services (Eliot) to send text messages to my cell phone to provide information to confirm upcoming appointments. I understand and accept the following:

- I understand that I am expected to respond to automated text messages to confirm my upcoming appointment and that if I do not confirm the appointment through the text message my appointment may be canceled.
- At no time will Eliot disclose any PHI about me through text message.
- I understand that standard text messaging rates will apply to any messages received from Eliot.
- I understand that this is an automated service and I am not able to communicate directly with my clinician and/or Eliot employee through this service.
- I understand that I may revoke this consent at any time.

Telehealth

I authorize Eliot Community Human Services (Eliot) to provide services via Telehealth technology. I understand and accept the following:

- I understand that telehealth is the use of electronic information and communication technologies by an authorized provider to deliver services to an individual when he/she is located at a different site than the provider.
- I understand that I will be provided necessary support and assistance with accessing and using the technology that Eliot utilizes to provide telehealth services.
- I understand the potential risks associated with this technology:
    - The video connection may not work or stop working during services.
    - I may be required to go to the location of the provider if it is felt that I would be better served in an in-person meeting.
- I understand that there are risks and consequences from telehealth including but not limited to, the possibility that, despite reasonable efforts on the part of Eliot Community Human Services, the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.
- I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my provider believes I would be bettered served by other interventions I will be asked to go to the location of the provider for in-person services.
- I understand that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. I understand that an emergency situation may include feeling suicidal, having thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, being in a life threating or emergency situation, and/or abusing drugs or alcohol and am not safe.

- I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth. As always, your insurance carrier will have access to your medical records for quality review/audit.
- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time. As long as this consent is in force (has not been revoked) Eliot Community Human Services may provide services to me via telehealth without the need for me to sign another consent form.

Discharge from Services

Discharges from services will be planned with you when you no longer require or benefit from services. You will be provided referrals to other support services as applicable/indicated.

ELIOT COMMUNITY HUMAN SERVICES, INC
125 Hartwell Ave, Lexington, MA 02421

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this Notice of Privacy Practice ("Notice"), please discuss it with the staff member of Eliot Community Human Services, Inc. ("Eliot" or "we") involved with your care. You may also speak with the Eliot's Privacy Officer, the Program Director or Human Rights Officer, or their supervisors.

I. INTRODUCTION:

This Notice of Privacy Practices ("Notice") describes how Eliot may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice applies to the privacy practices of all Eliot programs. The Notice also describes the obligations we have to protect your privacy as well as your rights regarding the protected information we maintain about you. Anyone who is a client of the organization and receives services at any of our locations will receive a copy of this Notice. A copy of the current Notice is also posted at each of Eliot's offices and is available on our website at: **www.eliotchs.org.**

Protected Health Information
Protected Health Information ("PHI") is any information about your past, present or future health care, or payment for such care.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information ("PHI") and to provide you with this Notice of our legal duties and practices with respect to it. We will not use or disclose your PHI without your authorization, except as described by this Notice. You may request a paper copy of this Notice at any time.

II. HOW WE MAY USE AND DISCLOSE YOUR PHI.

We may use and disclose your PHI for many different reasons. For some of these uses or disclosures, we need your written authorization. Below we describe each category of uses and disclosures and provide you with some examples. Except when disclosing PHI relating to your treatment, payment or health care operations, we must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

A. Uses and Disclosures That May Be Made For Treatment, Payment and Operations:

1. For Treatment: We may use or disclose your PHI to manage, coordinate and provide your health care treatment and related services. For example, we may disclose information to Eliot team members who are involved with managing and providing your care. However, your PHI may be used and disclosed without

your authorization in order to discuss your care amongst our clinicians and other staff (including clinicians other than your therapist or principal clinician), who work at Eliot, or coordinate your health care and related services with a health plan case manager who is responsible for managing your care. In addition, we may disclose information to other non-Eliot providers, such as your physician, therapist, social worker, or other health care personnel. In such case, we will obtain your authorization (usually written) prior to the disclosure. In certain instances your treatment at Eliot may be conditioned upon obtaining a signed authorization from you (e.g., when treatment requires communication with key, external healthcare providers or when treatment is solely provided for the purpose of creating PHI for disclosure to a third party, or when research-related treatment requires disclosure of PHI).

2. For Payment: We may use or disclose your PHI without your authorization so that the treatment and services you receive are billed to, and payment is collected from your health plan or other third party payers. For example, we may disclose your PHI to permit your health plan to take certain actions before your health plan approves or pays for your services. Your health plan may verify that services billed were actually provided to you or to determine if the insurer will approve future treatment. Your health plan may ask us to share your PHI in order to determine if the plan will approve additional visits to your provider, such as your therapist. Other reasons may include but not be limited to:

- Making a determination of eligibility or coverage for health insurance;
- Reviewing your services to determine if they were medically necessary;
- Reviewing your services to determine if they were appropriately authorized or certified in advance of your care; or
- Reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

3. For Operations. We may use and disclose your PHI without your authorization for health care operations that are necessary to run our organization and to ensure that our clients receive quality care. These activities may include:

- Quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, licensing, accreditation, business planning and development, and general administrative activities.
- We may combine the PHI of many of our clients to decide what additional services we should offer, which services are no longer needed, and whether certain new treatments are effective. We may also combine our PHI with that of other providers to compare how we are doing and determine where we can make improvements in our services. When we combine our PHI with the PHI of other providers, we will remove all identifying information so others may use it to study health care or its delivery without identifying specific clients.
- We may use and disclose your PHI to contact you to remind you of your appointment or to communicate a scheduling change.
- We may use and disclose your PHI to inform you about possible treatment options or alternatives that may be of interest to you.

4. Marketing and Fundraising. We may contact you as part of fundraising efforts. If you do not wish to be contacted for such purposes, you have the right to opt out of receiving such communications.

B. Uses and Disclosures That May be Made Without Your Authorization, But For Which You Will Have an Opportunity to Object

In order to provide you with an appropriate level of service quality, we are permitted to use and disclose your PHI in the following ways. You have the opportunity to object to such practices.

- **Facility Directory**: Eliot maintains a limited facility directory within our residential programs and Crisis Stabilization Service for the purpose of allowing individuals to locate you. Only your name and telephone number will be given to callers who ask for you by name. If you are admitted to one of our residential programs or the Crisis Stabilization Service, you will have an opportunity to object to being included in our facility directory. If you choose NOT to be included in the directory, you will not be identified as a resident and your directory information will not be provided.
- **Persons Involved in Your Care**. If you are physically present and have the capacity to make health care decisions, your PHI may only be disclosed with your agreement to persons you designate to be involved in your care. However, we may use or disclose your PHI, as permitted by law.

C. Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object:

There are certain circumstances in which we are permitted and/or required to use and disclose your PHI without your authorization, for which you are not given an opportunity to object.

- Emergencies
- Research
- As Required By Law
- To Avert a Serious Threat to Health or Safety
- Organ and Tissue Donation
- Public Health Activities
- Health Oversight
- Medical Examiners or Funeral Directors
- Military and Veterans
- National Security and Protective Services for the President and Others
- Workers' Compensation

III. USES AND DISCLOSURES OF YOUR PHI WITH YOUR PERMISSION:

All other uses and disclosures of your PHI not otherwise or previously covered by this Notice generally will require your written permission, or an "Authorization," except as provided by law. Examples of uses and disclosures that require your authorization include, but are not limited to, most uses and disclosures of psychotherapy notes, drug and alcohol abuse treatment records, HIV testing or test results, uses and disclosures for marketing purposes if Eliot receives financial remuneration, and disclosures that constitute sale of PHI. Further, Eliot is prohibited from selling your PHI without your express written authorization. You have the right to revoke an Authorization at any time. And if you do so we will not make any further uses or disclosures of your PHI under that Authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized. To revoke an Authorization, contact your Primary Clinician, the Program Director or the Privacy Officer. All revocations must be submitted in writing.

IV. YOUR RIGHTS REGARDING YOUR PHI:

You have certain rights with respect to your PHI maintained by Eliot, as follows:

A. **Right to Inspect and Copy**: You have the right to inspect or copy your PHI that is used to make decisions about your care involving treatment or payment. Usually, this includes clinical and billing records, but does not include psychotherapy notes. To request an inspection and/or obtain a copy, you must submit your request in writing. In some instances, a summary of your PHI may be provided and, if you request a copy of your PHI, we may charge a fee for the cost of copying, mailing and supplies associated with your request. We may deny your request to inspect and/or copy your PHI in certain limited circumstances. If we deny your request, we will send you a written notice of the denial stating the basis for the denial. In some cases, you will have the right to appeal a denial, and we will inform you of this in writing. If so, it will be reviewed by a licensed health care professional not directly involved in the original decision to deny access. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer.

B. **Right to Amend**: For as long as we keep records about you, you have the right to request us to amend any PHI used to make decisions about your care, whether they are decisions about your care involving treatment or payment. Usually, this includes clinical and billing records. To request an amendment, you must submit a written request indicating why you believe the PHI is incorrect or inaccurate, and how you want it changed. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend PHI that:

- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- is not part of the PHI we maintain to make decisions about your care;
- is not part of the PHI that you would be permitted to inspect or copy; or
- is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the PHI that is the subject of your request. If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the PHI that are the subject of your request.

C. **Right to an Accounting of Disclosures**. You have the right to request that we provide you with an accounting of disclosures or, in other words, a list of instances when your PHI has been released. You may request an accounting as far back as six years, except requests for electronic disclosures relating to treatment, payment or health care operations which are limited to three years. The accounting will not include (i) non-electronic disclosures relating to treatment, payment or health care operations; (ii) disclosures if you gave your written authorization to share the information; (iii) disclosures shared with individuals involved in your care; (iv) disclosures to you about your health condition; (v) disclosures made for national security or intelligence purposes or to correctional institutions or law enforcement officials who have custody of you. We will respond to your request within 60 days of receiving it. The first accounting you request within a twelve

month period will be free. For additional requests during the same 12 month period, we may charge you for the costs of providing the accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time.

D. **Right to Request Restrictions**: You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. You may also ask that any part (or all) of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in Section II(B)(2) of this Notice. You must make your request in writing to your Primary Clinician, Program Director, or Privacy Officer. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment. We may terminate a restriction when medically or legally necessary, but we will contact you prior to any such termination.

F. **Right to Restrict Disclosure:** You have the right to restrict certain disclosures of PHI to a health plan if you pay out of pocket in full for the health care service.

G. **Right to Request Confidential Communications**: You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work. To request such a confidential communication, you must make your request in writing to your Primary Clinician or Program Director. We will accommodate all reasonable requests. You do not need to give us a reason for the request; but your request must specify how and where you wish to be contacted.

H. **Breaches:** Individuals whose PHI has been breached will be notified in writing as required by law.

IV. CONFIDENTIALITY OF SUBSTANCE ABUSE RECORDS

For clients who have received treatment, diagnosis or referral for treatment from our drug or alcohol abuse programs, the confidentiality of drug or alcohol abuse records is further protected by federal law and regulations (42 U.S.C. § 290dd-2 for federal law and 42 C.F.R., Part 2 for federal regulations). As a general rule, we may not tell a person outside the programs that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless:

- you authorize the disclosure in writing; or
- the disclosure is permitted by a court order; or
- the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation purposes; or
- you threaten to commit a crime either at the drug abuse or alcohol program or against any person who works for our drug abuse or alcohol programs.

A violation by us of the federal law and regulations governing drug or alcohol abuse is a crime. Suspected violations may be reported to the Unites States Attorney in the district where the violation occurs. Federal law

and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities.

V. REVISIONS TO THIS NOTICE:

Eliot reserves the right to change the terms of this Notice. We also reserve the right to make the revised or changed Notice effective for all PHI we already have about you as well as any PHI we receive in the future.

We will post a copy of the current Notice at each program site where we provide care. You may also obtain a copy of the current Notice by calling the Eliot program involved in your care, and requesting that a copy be sent to you in the mail or by asking for one any time you are at the program site office.

VII. COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer listed below. To file a complaint, you may also ask to speak to your Primary Clinician or the Program Director who will assist you with writing your complaint upon request.

Privacy Officer
Eliot Community Human Services, Inc.
125 Hartwell Avenue
Lexington, MA 02421
781-861-0890
You may also file a complaint with the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, at (617) 565-1340.

Revised: 1/06; 7/12; 11/13