Winchester Community
Mental Health Center, Inc.

Client Name: _____ **Date of Birth:** _____ **MR#:** _____

Demographic Sheet

Gender: ☐ Male ☐ Female Age: _____ Social Security #: _____

Address: _____City: _____ Zip Code: _____

Home Phone#: _____ Can we leave a message on your home phone? ☐ Yes ☐ No

Cell Phone #: _____ Can we leave a message on your cell phone? ☐ Yes ☐ No

Email Address: _____

Occupation: _____ Employer/ School: _____

Work Phone #: _____ Can we leave a message on your work phone? ☐ Yes ☐ No

Marital Status: _____

Spouse's Name: _____ Social Security #: _____

Age: _____ Date of Birth: _____ Employer: _____

Occupation: _____ Cell Phone #: _____

Work phone #: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ ID/ Member #: _____

Group #: _____ Policy/ Plan #: _____

Name of Insured: _____ Insured's SSN: _____

Insured's DOB_____

SECONDARY INSURACE INFORMATION (IF APPLICABLE):

Insurance Company: _____ ID/ Member #: _____

Group #: _____ Policy/ Plan #: _____

Name of Insured: _____ Insured's SSN: _____

Insured's DOB_____

EMERGENCY CONTACT

Name of Emergency Contact: _____

Relationship to Client: _____ Emergency Contact Phone: _____

Winchester Community
Mental Health Center, Inc.

Client Name: _____ **Date of Birth:** _____ **MR#:** _____

Parent Information (IF PATIENT IS A MINOR) ☐ **N/A- Patient is not a minor.**

Father's Name: _____ Home Phone _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Mother's Name: _____ Home Phone: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone: _____

I was referred by: _____

Relationship to you: _____

******Be sure to provide the Receptionist with your insurance card(s) and a picture ID.*********

Client/ Parent Signature: _____ Date: _____

Staff Printed Name: _____

Staff Signature: _____ Date: _____

Winchester Community
Mental Health Center, Inc.

Client Name: _____ **Date of Birth:** _____ **MR#:** _____

ASSIGNMENTS OF BENEFITS
RELEASE OF LIABILITY & MEDICAL INFORMATION

I hereby authorize and request that insurance benefit payments by my insurance company

_____
(Name of your insurance company)

be made directly to Winchester Community Mental Health Center ("Facility") for services provided to me or my dependent by the facility. I understand that my insurance company may only cover a portion of the total bill and that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Winchester Community Mental Health Center, Inc. to disclose any and all written information to my above-named insurance company and/ or its designated representatives, at the determination of the facility. Such disclosure shall be for reimbursement purposes for those services provided by the facility.

I hereby release the facility, its officers, agents, employees and any clinician associated with my treatment, from all liability that may arise as a result of discloser of information to the above-named insurance company or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company or their designated representatives request records of information for reimbursement purposes.
2. I agree to participate and assist the facility or its designated representatives with any appeal process necessary to collect payment for services rendered. I hereby appoint the facility as my appointed representatives in any insurance provider or fiscal intermediary case reconsideration and/or appeal procedure to act on my behalf.
3. I am aware and have been advised of the provisions of Federal and State Statutes, rules and regulations that provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. I understand that the ultimate financial responsibility is mine and verification of insurance is **not** a guarantee of payment
    - Billing may be done by a firm contracted by the facility for billing and collection purposes.
    - Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
    - The facility shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____ _____
Client Signature **Legal Guardian**

_____ _____
Staff Printed Name & Signature **Date of Signature(s)**

REVISED 04.27.2023 HM

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

Appointment Responsibility Contract (Medicaid)

Date: _____

I, _____, understand and agree to the following:
(Please print client's first and last name OR if the client is a minor, print the parent/guardian's name)

- I am responsible for scheduling, keeping and for being on time for my appointments.
- I understand the office may contact me for a reminder call, as a courtesy, but I understand the responsibility for keeping my appointment is ultimately mine.
- I will call WCMHC at least 48 hours before my scheduled appointment to cancel and/or reschedule my appointment if I cannot keep it.
- I understand missed appointments will be considered a "No-Show" if I do not provide a 48-hour notice.
- I will receive a warning letter if I "No-Show" **one (1)** appointment or have excessively rescheduled or cancelled appointments.
- I will be discharged if I "No-Show" **two (2)** appointments or have excessively rescheduled or cancelled appointments. If I receive a discharge letter, I understand I will not be eligible to re-initiate services at WCMHC for 6 months.

_____ _____
Signature of Client Date Signature of Parent/ Advocate Date

_____
Staff Printed Name & Signature Date

Winchester Community
Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

LIMITS OF CONFIDENTIALITY (VIRGINIA)

Federal and State of Virginia Laws and Regulations protect the confidentiality of client records maintained by this facility. Generally, the facility may not say that a client attends the facility or disclose any information identifying a client unless:

1. **Risk of self-harm**: During your session, if you present a threat level, words, or behavior that convince your therapist that you are likely to harm yourself, either deliberately or because you are unable to keep yourself safe, your therapist must do whatever he or she can to prevent you from being harmed
2. **Risk of harm to others**: During your session, if you present a threat level toward another person, words, or behavior that convince your therapist that you are likely to harm another person, your therapist must try to protect that person. He or she would report your threat to the police, warn the threatened person, and try to prevent you from carrying out your threat. Federal and State of Virginia Laws and Regulations do not protect any information about a crime committed or intent to commit a crime by a patient either to themselves or others.
3. If your therapist obtains information leading him/her to **believe or suspect abuse** of a child, senior citizen, or disabled person, the therapist must report this to a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. The therapist cannot investigate and decide whether abuse is taking place - if the suspicion is there, the therapist must report it. Federal and State of Virginia Laws and Regulations do not protect any information about suspected abuse and neglect from being reported.
4. **Children and adolescents**: It is the policy of this agency, when a therapist treats children and adolescents, to ask their parents or guardians to agree that most details of what their children or adolescents tell the therapist will be treated as confidential. However, parents or guardians do have the right to general information about how therapy is going. The therapist may also have to tell parents/guardians about information if their children or others are in any danger.
5. **Couples**: If one member of a couple tells a therapist something the other member does not know, and not knowing this could harm him or her, the therapist cannot promise to keep it confidential from the other person. If this occurs, the therapist will discuss it with you before doing anything else.
6. **In group therapy**: The other members of the group are not therapists. They are not bound by the ethical rules and laws governing therapists. To avoid problems in this area, it is this agency's policy to ask all members of therapy groups to agree to protect one another's confidentiality, and to remove from the group any member who does violate another member's confidentiality. Still, this agency cannot be responsible for such disclosures by other clients, and it may be better for you to discuss information you feel must be legally protected in an individual session with your therapist than in a therapy group session.
7. This agency will not record therapy sessions on audiotape or videotape without your written permission.
8. If a judge court orders your therapist to provide information about your history or your treatment, the therapist must do so as required by federal laws and/or regulations.
9. This disclosure is made to medical personnel in a medical emergency.
10. Your therapy and/or medication management clinician may consult with other Winchester Community Mental Health, Inc. therapy and/or medication management clinicians and/or supervisors to provide the best possible care. These consultations are for professional and training purposes only.

Violation of Federal and State of Virginia Laws and Regulations by a facility is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal and State of Virginia regulations.

Client Statement: I have read this information pertaining to the confidentiality of client records and understand it as written.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

NOTIFICATION OF CLIENT RIGHTS (VIRGINIA)

1. Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats, and exploitation, and (e) all forms of seclusion and restraint.

2. Be fully informed about the course of your care and decisions that may affect your treatment.

3. Revoke your consent for treatment at any time.

4. Timely and accurate information to assist you in making sound decisions about your treatment

5. The right to be informed how to access self-help services, legal entities for appropriate representation, and advocacy support services.

6. Be fully involved as an active participant in decisions pertaining to your treatment.

7. The right to freedom from unnecessary or excessive medication.

8. Have an individual identified in writing that will direct and coordinate your treatment.

9. The right to be informed of and refuse any unusual or hazardous treatment procedures.

10. The right to agency adherence to research guidelines and ethics, if applicable.

11. Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations.

12. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.

13. File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort.

14. Have family members, friends or others involved in your treatment with your consent and approval.

15. Receive services that comply with all applicable federal and state laws, rules and regulations.

16. File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit.

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

NOTIFICATION OF CLIENT RIGHTS (VIRGINIA)

17. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay.

18. To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences.

19. You may also have additional rights afforded to you based on federal, state, and local regulations.

Your service coordinator will advise you of any additional rights that you may have.

Please speak with the Clinical Director if you have concerns or problems with any of the Winchester Community Mental health Center, Inc. policies or staff. We want to serve and provide you with excellent service and respect.

Clinical Director: Mary Zirkle, MS, LPC (540) 535-1112
Or Complaint: 1-800-955-1819

If you are not satisfied with our solution or continue to have problems or concerns, please call your Local Human Rights Advocate.

Human Rights Advocate: Cassie Purtlebaugh (804) 382-3889

All clients have the right to a complaint resolution, hearing, and appeal procedure.

I also understand the following regarding Winchester Community Mental Health Center, Inc:

- All clients will be expected to cancel appointments with at least 48-hour prior notification.
- A fee will be charged upon request for completion of outside paperwork; payment must be confirmed prior to completion.
- All clients are expected to be on time to their appointments.
- No firearms, pellet guns, air rifles, or other weapons designed or intended to propel a missile of any kind by any action of explosion or combustible material allowed on premises.

Winchester Community Mental Health Center, Inc. is a private place of business. We do have the right to decline or terminate services if necessary.

The Human Rights have been explained to me and a copy of the Human rights and Regulations Booklet has been offered to me.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

REVISED 09.9.2022 HM

Winchester Community
Mental Health Center, Inc.

Client's Name: _____ Date of Birth: _____ MR#: _____

ADVANCED DIRECTIVES

Location of Services (Please *select one*):
☐ 36 Ricketts Drive Winchester, VA 22601
☐ 105 Stony Pointe Way Strasburg, VA 22657
☐ 123 Hovatter Drive Inwood, WV 25428

Advanced Directives:
I have received written information regarding my rights to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate Advance Directives under state law. (Please see the Client Handbook and the Human Rights and Regulations form)

Client has developed an Advanced Directive: ☐ Yes ☐ No

If no, stop here and let the client know that assistance in developing an Advanced Directive is available through various national and state resources, such as www.caringinfo.org.

If an Advanced Directive has been executed it is in the medical record, unless the client does not wish to have it filed.

☐ Client declined Advanced Directives.

Client has a living will: ☐ Yes ☐ No

If yes, location of Living Will: _____
I have a patient advocate/ proxy is:
Name: _____
Address: _____
Phone: _____

☐ I do not desire to complete a durable power of attorney for health care
☐ I do desire to complete a durable power of attorney for health care
☐ I have a Durable Power of Attorney for health care

☐ I have a directive to physicians
☐ I desire to complete a directive to physicians
☐ I do not desire to complete a directive to physicians

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

REVISED 04.27.2023 HM

Winchester Community
Mental Health Center, Inc.

Privacy Notice

Notice of Privacy Practices-Effective September 18, 2014 *Replaces August 23, 2013
Privacy Notice*

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, please contact the Clinical Director or our Privacy Officer at the telephone numbers and addresses listed at the end of this notice.

WHAT IS MY PROTECTED HEALTH INFORMATION (PHI)?

Anything from the past, present, or future about your mental or physical health condition that is spoken, written, or electronically recorded, and is created by or given to anyone providing care to you, such as, a health plan, a public health authority, your employers, your insurance company, your school or university, or anyone who processes health information about you.

OUR OBLIGATIONS:

- Maintain the privacy of protected health information;
- Keep medical records that identify private information about you;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

For Treatment- We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment- We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations- We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. We may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care- When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research- Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law- We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety- We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates- We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation- If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation or organs, eyes, or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans- If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation- We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks- We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reaction to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities- We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes- We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes- If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request of to obtain an order protecting the information requested.

Law Enforcement- We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identify, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors- We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities- We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others- We may disclose Health Information to authorized federal officials, so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety of the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT:

Individuals Involved in Your Care or Payment for Your Care- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief- We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do not give us authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosures that we made in reliance on your authorization before you revoked it will not be affected by this revocation.

CAN I REVOKE MY CONSENT?

Yes, you can revoke your consent. You must do this in writing and bring it to us so that we can stop using and disclosing your Protected Health Information. We are permitted to use and disclose your Protected Health Information based on your consent until we receive your revocation in writing. However, if you revoke your consent, we reserve the right to refuse to provide further treatment to you, on the basis of your refusal to allow us to share your information for purposes of treatment, payment, and healthcare operations.

Clinical Director: Mary Zirkle, MS, LPC-S

Privacy Officer: Stacie Cain

Address: 36 Ricketts Drive, Winchester, VA 22601

Phone: (540) 535-1112

Winchester Community
Mental Health Center, Inc.

Winchester Community Mental Health Center
Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

Client Name (Please Print): _____

Client Date of Birth: _____ **MR#:** _____

I acknowledge that I have received a copy of WCMHC's HIPAA Notice of Privacy Practices

_____ _____
Client Signature **Date**

OR

_____
Parent/Legal Guardian/Personal Representative Name (Please Print)

_____ _____
Signature of Parent/Legal Guardian/Personal Representative **Date**

Authority of Personal Representative to Sign for Client **(check one)**:

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgment.

Winchester Community
Mental Health Center, Inc.

Client Name: _____ **Date of Birth:** _____ **MR#:** _____

VERBAL COMMUNICATION/CONSENT RELEASE

I, a patient of Winchester Community Mental Health Center hereby give consent for verbal communication by members of my Treatment Team to the following person(s):

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

LIMITATION: Verbal communication is limited to information regarding my treatment program. This authorization does not authorize dissemination of any portion of my medical record. This authorization is valid for the term of my treatment at Winchester Community Mental Health Center, plus ninety (90) days post discharge; unless revoked by me in writing, prior to that date. I hereby release Winchester Community Mental Health Center and all members of my treatment team from any liability which may arise as a result of information provided per the terms of this authorization.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

OUTPATIENT AFTER HOURS EMERGENCY POLICY AND PROCEDURE

POLICY:
If a client's condition deteriorates after program hours to require a level of intensity and security greater than what the Outpatient provides, the client or parent/guardian should call 911 or go to the nearest hospital.

PROCEDURE:

1. Should psychiatric emergency arise after program hours, the client and/or family member and/or significant other may contact the program at (540) 409-0638 at which time the answering service will immediately contact the Program Director. Should life endangering behavior be present, the answering service will immediately notify the caller to contact emergency services 911 or go to the nearest hospital and may initiate this call if necessary.

2. The Program Director, once notified, will then contact:

    a. The client's family member and/or significant other to gather further information on the client's current status and to take professionally indicated actions.

    b. In case of life-threatening behaviors, immediate contact with emergency services will be initiated to protect the life and safety of the client and/or others.

CLIENT/GUARDIAN STATEMENT: I have read and fully understand and agree to all conditions to this After Hour Emergency Policy and Procedures.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____
Staff Printed Name & Signature Date

Winchester Community
Mental Health Center, Inc.

Client Name: _____ **Date of Birth:** _____ **MR#:** _____

Orientation Checklist

The following information has been provided as part of the person served orientation. A check of the item and the signatures below indicate that each area has been fully explained and is understood by the person served.

_____ Rights and grievance and appeal procedures

_____ Services provided, days and hours of operation, expected level of participation

_____ Access to emergency services, after hours

_____ Code of ethics/conduct

_____ Confidentiality policy, limits of confidentiality

_____ Methods, opportunities, and policy on input

_____ Explanation of financial obligations, fees, and financial arrangements

_____ Fire, safety, infection control, and emergency procedures

_____ Policy on restraint

_____ Policy on tobacco products

_____ Policy on illicit or licit drugs brought into the program

_____ Policy on weapons brought into the program

_____ Identification of the person responsible for service coordination

_____ Program rules, including restriction and the loss of regaining of rights

_____ Purpose and process of biopsychosocial assessment

_____ Individual plan development

_____ Discharge/transition criteria and procedures

_____ Human Rights and how to report

_____ Procedure for reporting client abuse, neglect and/or exploitation

Client Signature: _____ Date: _____

Guardian or Parent/Advocate Signature: _____ Date: _____

Staff Signature and Name:_____Date: _____

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

Coordination of Care Form

THIS IS NOT A REQUEST FOR RECORDS AT THIS TIME. THIS IS A NOTIFICATION OF CLIENT'S SERVICES AT WCMHC.

READ THIS FIRST:
This form is to be completed if you wish to authorize your behavioral health provider to exchange information regarding your behavioral health condition with your primary care provider or other behavioral health providers who may be directly involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission.

☐ **I hereby refuse to exchange information with my primary care provider or other behavioral health providers. (If client refuses, have client sign and do not complete the information below).**

Primary Care Physician or Group Practice Name: _____
*(*please indicate if none at this time)*

Phone Number:_____ **Fax Number:** _____

Client Information
WCMHC Provider: _____ **First date of service:** _____

Location of WCMHC Services: (Please *select one*):
☐ 36 Ricketts Drive Winchester, VA 22601 Phone: (540) 535-1112
☐ 105 Stony Pointe Way Strasburg, VA 22657 Phone: (540) 465-9606
☐ 123 Hovatter Drive Inwood, WV 25428 Phone: (304) 901-5801

The Client is Receiving:
☐ Group Therapy Services ☐ Medication Management ☐ Intensive In-home services
☐ Substance Abuse Treatment ☐ Individual Therapy ☐ Mental Health Skill-Building services
☐ Family Therapy ☐ Partial Hospitalization Program
☐ Intensive Outpatient Therapy ☐ Couples Therapy
☐ Relevant information:_____

Complete your acknowledgement that you understand that:
- You have the right to review the information that is being used or disclosed.
- You do not have to complete this authorization and your refusal will not affect your benefits.
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.
- It is your responsibility to notify your Behavioral Healthcare Provider if you choose to change your Primary Care Physician.
- You have a right to revoke this authorization at any time.

_____ _____
Signature of Client, Parent, Guardian, or Authorized Representative Date

_____ _____
Authorized Staff Signature and Printed Name Date

REVISED 09.09.2022 HM

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

Tele-Therapy and Tele-Medication
Limits of Confidentiality

What is Teletherapy or Telehealth/Tele-Medication?
Teletherapy, Telehealth/Tele-Medication, involves the use of electronic communications to enable physicians and other healthcare professionals, including mental healthcare professionals, to improve the access to quality and appropriate care. Teletherapy includes the practice of health-care delivery, evaluation diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Treatment Providers may include, but are not limited to, psychiatrists, psychologists, nurses, counselors, clinical social workers, and marriage and family therapists.
Teletherapy services are also available for face-to-face clients on an as needed basis if deemed to be necessary and appropriate for treatment. At this time teletherapy services are only being offered via videoconferencing and the telephone.

Risks and Benefits
In addition to the risks and benefits outlined in the Informed Consent, Teletherapy has its own unique risks and benefits. Benefits include improved access to care for clients who are homebound, lack reliable transportation, or do not have providers near them. Teletherapy can be beneficial for those who are more comfortable communicating online rather than face to face. Teletherapy often offers more flexibility with scheduling. Risks include but aren't limited to unexpected technological failures during sessions; increased risks to privacy which creates an additional burden on the client to ensure that sessions are private and undisrupted; hacking. An important risk to consider is the lack of nonverbal communication (body signals) that are readily available to both therapist and client in face-to-face sessions. Without this information, teletherapy may be slower to progress or be less effective altogether.

Client Records
All records are kept in written, hard copy form and stored at Winchester Community Mental Health Center located in Winchester, VA or Inwood, WV. All records are stored for seven (7) years. Clients and Parents/Legal Guardians of Minor Clients have the right to request a copy of the record or a brief summary. All records request must be submitted in writing and are subject to a fee.

Verification of Client Identity
At the initial session the client will be required to provide proof of identity.

Technological Failures
Should a video or telephone session experience a disruption/technological failure the therapist will re-establish the connection (place a new video or telephone call) unless other arrangements between client and therapist are agreed upon. If videoconferencing is temporarily unavailable the session will resume via telephone (in accordance with the client's consent for communication form.) If after 15 minutes connection can't be re-established, or the session resumed on the phone then the session will be rescheduled. If the technological failure occurs on the therapist's end the client will not be charged for the appointment; if the failure occurs on the client's end, they are still subject to the full session fee (pro-rated session rates not available).

Emergencies
Emergency procedures laid out in the Informed Consent form apply. Given that therapy is not being conducted face to face, I do require all teletherapy clients have an emergency contact on file (additional release will be provided).

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

Tele-Therapy and Tele-Medication
Limits of Confidentiality

Best Practices

To create an environment that is as close to a face-to-face experience as possible the following guidelines are strongly recommended:

A. Ensure that your location is private and secure. Try to conduct your session in a room that allows you to separate yourself from distractions and any non-participants in the home who might overhear. Make arrangements for childcare if possible.

B. If the session is being conducted through video chat:

a. Make sure there is enough lighting. Dark and solid colored clothing works best and lowers risk of interference with video image. Avoid large pieces of jewelry that reflect light. Take off hats and sunglasses that limit the view of your face.

b. Only use a Wi-Fi network that is secure via password protection, no public Wi-Fi

c. Position yourself and camera so that you are visible from at least the waist up. If there are multiple participants make sure everyone is in view.

I understand that teletherapy services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic and/or medication management services (e.g. face-to-face services) I will be referred for face-to-face sessions.

I understand that there are potential risks and benefits associated with any form of medication management and/or psychotherapy, and that despite my efforts and the efforts of my medical provider and/or therapist, my condition may not improve, and in some cases may even get worse.

I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my medical provider and/or therapist.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy.

I understand that the information disclosed by me during my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality as outlined in the main informed consent form.

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of teletherapy and/or Tele-Medication during my care at any time, without affecting my right to future care or treatment.

_____ _____

Signature of Client Date Signature of Parent/Advocate Date

_____ _____

Staff Printed Name Staff Signature Date