**Greene County Mental Health Center**

**905 Greene County Office Building**

**Cairo, New York 12413**

**(518) 622-9821 — (518) 622-9163 — Fax: (518) 622-8592**

**Maggie Graham, APRN-BC, Director of Community Services**

PATIENT BILL OF RIGHTS

**YOU HAVE THE RIGHT:**

* To quality care and treatment
* To be treated with dignity & respect
* To know about and help plan all aspects of your care, treatment and recovery program
* To object to any part of your care and treatment which you do not feel is helping you (except when there is risk of harm to yourself or others)
* To appeal any decisions about your program and to have those decisions reviewed by a higher authority
* To have all medical records and files kept private
* To have an individual program based on your changing needs
* To review treatment records and receive a copy of the records
* To participate voluntarily in and consent to treatment
* To have access to the advocacy groups listed below:

**NYS Commission on Quality of Care for the Mentally Disabled**

401 State Street, Schenectady, NY 12305

518-388-2888

**NYS Office of Mental Health**

44 Holland Avenue, Albany, NY 12229

800-597-8481

**National Alliance for the Mentally Ill of NYS**

260 Washington Avenue, Albany, NY 12210

518-462-2000

**Protection & Advocacy for Individuals Who Are Mentally Ill**

**PAIMI of Hudson Valley Region**

155 Washington Ave., Suite 300, Albany, NY 12210

518-432-7861

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## Cairo, New York 12413

* + 1. Fax: 518-622-8592

*Please Print Clearly* Face Sheet For Office Use Only

 *Confidential*  Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Intake Person\_\_\_\_\_\_\_\_\_\_\_

**Patient Information Only:**

Social Security Number:\_\_\_\_\_\_\_--\_\_\_\_\_\_\_--\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_ Zip:\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_--\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_\_

Physical Address : [ ] Check if same as mailing address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_ Zip:\_\_\_\_\_\_\_\_

If Student - School District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**If patient is a minor:\_\_**

[ ] Mother or Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Guardian Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_-\_\_\_\_\_\_

[ ] Father or Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Guardian Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone: (\_\_\_ \_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_

**Primary Care Physician:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of Emergency, Contact: Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Members of your Household:**

 Name Relationship Age Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Party Responsible for Insurance. If self, please list your name exactly as it appears on your insurance card.

Insured’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment #: \_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_--\_\_\_\_\_\_\_

Self Pay (Y/N) \_\_\_\_\_\_ Note\*\* *If (yes) please ask receptionist for self-pay form*

Primary Insurance Company/Medicare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

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**UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS**

AUTHORIZATION FOR RELEASE OF INFORMATION BY THE GREENE COUNTY MENTAL HEALTH CENTER: I hereby authorize and direct the Greene County Mental Health Center, having treated me, to release to government agencies, insurance carriers, or others who might be financially liable for my medical care, all information needed to substantiate payment for such medical care.

ASSIGNMENT OF BENEFITS TO THE GREENE COUNTY MENTAL HEALTH CENTER: I hereby assign and set forth to the Greene County Mental Health Center, sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent by the Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WITNESS SIGNATURE OF PERSON

 TREATED OR AUTHORIZED

 REPRESENTATIVE

**FOR CLIENTS WHO ARE ENTITLED TO MEDICARE BENEFITS**

MEDICARE ASSIGNMENT: I hereby certify that the information given in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WITNESS SIGNATURE OF PERSON

 TREATED OR AUTHORIZED

 REPRESENTATIVE

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**CONSUMER INFORMED CONSENT & SERVICE AGREEMENT**

Welcome to Greene County Mental Health Center. As we begin our work together, there are a few things you should know that will help you best use our services. Please direct any questions about this service agreement to your intake worker.

**GCMH’s Responsibility to You:**

* We will provide you with mental health treatment for your specific condition. We are licensed to provide individual, group and family outpatient treatment. We will coordinate our treatment with any other providers involved with your care.
* We will inform you if we believe that your need for treatment exceeds our abilities or if we believe that you are not in need of our services. We will also make the appropriate referrals whenever possible and assist you in getting the correct level of care.
* We will supply you with a treatment environment that assists you in your efforts to help yourself. On that order, the clinic’s staff will be timely for your appointments, respect your privacy, make reasonable accommodations if you have a disability that makes engaging our service difficult, respect your decision to stop treatment, and provide you with recourse if you have a complaint about our service without fear of reprisal.
* We follow the New York State Office of Mental Health Rights of Outpatients that is posted at every licensed site. It contains your rights as a consumer and whom you can contact if you feel you are not being treated fairly.
* **If you have any after-hours emergencies that cannot wait until the next business day, you can reach our on-call clinician at 518-622-3344.**

**Your Responsibility to GCMH:**

* While in treatment you will be expected to participate in planning your treatment and following through. You may be asked to do homework, participate in groups, or sign releases of information, if indicated for your treatment. \_\_\_\_\_\_\_\_\_\_

Client Initials

* While in treatment you will be expected to communicate to your clinician any changes you experience that directly affect your treatment. For example, if you are in treatment for depression and you start to have suicidal thoughts, we expect you to notify your clinician or other staff of that development. Another example would be if you are getting substance abuse treatment and you relapse. Your clinician needs to know so that we can help you. \_\_\_\_\_\_\_\_\_\_

Client Initials

* While in treatment you are expected to pay any fees or make arrangements to have the fees paid by a third party. You will be expected to work with our clinic on questions regarding your insurance or managed-care company. \_\_\_\_\_\_\_\_\_\_

Client Initials

* While in treatment you are expected to cancel appointments 24 hours in advance. Failing to do so is considered a “Missed Appointment.” If you fail to cancel 24 hours in advance or miss any appointments without notice, the clinic reserves the right to charge you for such missed appointments. Failure to attend scheduled appointments could result in your termination from the clinic. It is your responsibility to obtain a follow-up appointment from your clinician if you cancel or miss an appointment. \_\_\_\_\_\_\_\_\_\_

Client Initials

**Limits of Confidentiality:**

GCMH closely adheres to New York State Mental Hygiene Law and to Federal Guidelines regarding confidentiality of mental health, substance abuse, and HIV information. All information about your treatment is confidential as defined by the above laws.

Most disclosures occur only when you sign an authorization form allowing us to release information about you and your treatment. This is the primary method that GCMH uses to release information to anyone, including a family member. Please note that any information that is disclosed will be limited to what you and your clinician decide to be appropriate for the situation. There are, however, the following exceptions to confidentiality that are important to be aware of:

* We are ethically and legally obligated to disclose relevant information in the event of various emergency situations, such as if we believe that you or another person in the community may be at risk to serious harm. At those times we are obligated to inform authorities and/or the person targeted for harm. There are also other emergency situations in which the Mental Health Association of Columbia & Greene Counties’ Mobile Crisis Assessment Team (MCAT) may be notified to intervene in an emergency situation in order to ensure your well being.
* We are not permitted to contact family members in the event of an emergency. You, however, can authorize Greene County Mental Health Center to do so by filling out the attached emergency form. We will only use this in the event of an emergency.
* We are allowed, and at times required, to disclose information under various legal compulsions such as: when child abuse or neglect is suspected or has occurred, when New York State Mental Hygiene Legal Services request information, to attorneys challenging involuntary hospitalization, to the NYS Commission on Quality of Care or its representatives, to NYS Board for Professional Medical Conduct, to the local director of mental hygiene, or when we receive an authorizing court order from a judge. All of these situations tend to be very rare.
* We are allowed to disclose information if a crime has been committed on the premises or against clinic personnel. We will only disclose to the authorities the minimal amount of information necessary for law enforcement to conduct their duties.
* We are allowed to disclose information with other providers who are involved or are planning to be involved in your care. This may include your primary care physician or other agencies, such as Twin County Recovery Services, Mental Health Association (MHA) of Columbia and Greene Counties, MHA’s Mobile Crisis Team, and Columbia Memorial Hospital. While we have the right to disclose certain pertinent information to coordinate care and/or an emergency response, whenever possible we will ask for your permission to do so prior to any release of information.
* We will not re-disclose any information that we receive from other treatment providers.

Please know that regardless of the circumstances, it is always our ethical and legal obligation to disclose only the minimal amount of information relevant to the particular situation. It is also our ethical obligation to discuss with you any information that is shared with other professionals, except in emergencies where we are unable to do so.

**GREENE COUNTY MENTAL HEALTH CENTER**

**CONSUMER INFORMED CONSENT & SERVICE AGREEMENT**

Thank you for reading the Greene County Mental Health Center Consumer Informed Consent and Service Agreement. Please direct any questions about this agreement to your clinician.

Please complete the form below confirming you have read the agreement, understand its contents, and agree to its terms.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Greene County Mental Health Center utilizes an automated telephone service that notifies you of your future appointments. If you would like to opt out of this appointment reminder system please check the box below.***

***[ ]  I do not wish to have automated reminder calls about my upcoming appointments.***

By signing below I acknowledge that I have read this agreement, understand its contents, and agree to its terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or

Legal Guardian (if client is under 18 years of age)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# PERMISSION TO TREAT A MINOR

## I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission

 Parent/Guardian

for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to receive

 Name of Minor

mental health services from Greene County Mental Health Center.

I understand that proper treatment of my child’s psychiatric condition

may require medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature if of Parent/Guardian) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of Therapist) Date

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**POLICY ON FAMILY INVOLVEMENT and MISSED APPOINTMENTS**

**Family Involvement**

* Family involvement is a mandatory part of your child’s treatment.
* You must make a commitment to face-to-face contact and/or telephone communication with the therapist to keep your child’s case open. Your child’s therapist will discuss this with you during the assessment process.
* Family involvement is important because:
	+ It provides feedback on your child’s behavior and mood at home.
	+ It assists the therapist in determining if there are ways your family can help your child meet his/her goals in therapy.
* At least one parent/legal guardian must accompany the child to medication management appointments.

**Making Your Appointments**

* Therapy is most successful when patients attend their sessions regularly.
* If your scheduled appointment must be canceled, please do so 48 hours prior to the appointment time.
* If you fail to make your appointment or cancel on the same day of the scheduled appointment, this will be considered a “no-show/missed appointment.”
* After two or more “no-show/missed appointments” for therapy or medication, your case may be closed.
* When your case is closed, all clinic-related services are terminated, including both verbal therapy and medication management.

Please indicate that you have read and agree to this policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Signature Date