Welcome to CoveCare Center

This handbook is for all clients of COVECARE CENTER. It has important information about how we can work together. Many people use our buildings to work, learn and recover. We all must care for each other and our space.

This handbook does not cover all situations or all procedures or policies. If you have questions, please speak to a COVECARE CENTER staff member.

Our Mission: To partner with individuals, families, and the community to foster hope, wellness, and recovery, and to restore quality of life by addressing mental health needs, substance use, and social and emotional issues.

Our Values:

- We foster hope.
- We know recovery is possible; people with mental health and substance use issues do not have to be limited by their diagnosis.
- We believe that recovery is a highly individualized process, and we focus on helping each person realize their strengths and dreams.
- We are passionate doing everything in our power to help people improve their lives and to better our community.

CoveCare Center has a full range of treatment and community support services. Please see our website at http://www.covecarecenter.org for more information or speak to a CoveCare staff member.

In-person and/or Tele-behavioral Health Services include:

- Mental Health Counseling and Treatment - Licensed therapists provide individual, group, and family therapy for adults and children. Psychiatrists and Nurse Practitioners prescribe and manage medications when needed. Trained Peer Specialists provide guidance and support based on lived experience.
- Alcohol & Substance Use Treatment – Credentialed counselors and clinicians provide individual, family, and group counseling services to adults and adolescents. Certified Peer Recovery Advocates provide guidance and support based on lived experience.
- Medication Assisted Treatment - MAT is the use of medication for the treatment of substance use disorders. This includes buprenorphine for the treatment of opioid use.

- Family Support Navigator Program – Trained staff assist families and individuals struggling with substance use by providing information and resources vital to recovery. This program provided free confidential services at a location of your choice.
- Personalized Recovery-Oriented Services – PROSper helps people, age 18 and up, with serious mental health issues recover, heal, and gain independence. Services include goal-oriented counseling, medication management and vocational counseling.
- Senior Partnership Services – Assessments, Care management, and counseling services offered in the community for adults aged 55 and older who are struggling with mental health and/or substance use.
- Community Based Services include Adult and Children's Care Management, Family Peer Support and Advocacy, Children and Family Treatment and Support Services (CFTSS), Home and Community Based Services (HCBS), Coordinated Children's Services Initiative (CCSI), Children's Respite Services, Supervised Visitation, Family Empowerment, and Rapid Re-Housing. Due to the variety of services offered within the Community Based Services department, CoveCare Center, staff will provide special attention to make sure you are in the right place.

*NOTE: Insurance eligibility applies when accessing specific services within CoveCare. Some services are at no cost.

Hours of Operation:

Monday – Thursday, 8:30AM - 8:30PM
Friday, 8:30AM - 5:30PM
Saturday, 8:30AM - 2:30PM

*NOTE: Specific program hours may vary. In-person hours may vary due to the pandemic.

Crisis Services:

Every person enrolled in CoveCare Center will have access to crisis services. If you are in crisis between 9am-5pm Monday - Friday and urgently need to speak to someone, one of our available professional staff may help you. Call 845 225-2700, then press 0.

For emergencies, you should always call 911 immediately.

Outside of the hours of 9:00AM – 5:00PM, on weekends, holidays, or any other agency closures, you will be referred to the after-hours crisis worker. Crisis calls after hours are triaged by Putnam County's Crisis Line who will ask for your name and call back information. CoveCare Center's crisis coverage worker will reach out to you within 15 minutes.

Please note: Crisis services will be provided over the phone after hours or through telehealth and/or in-person during the hours of 9:00AM to 5:00PM, Monday through Friday.

Frequently Asked Questions:

How much do the services cost?

- COVECARE CENTER strives to provide affordable mental health and substance use services to all. We accept most private insurances and Medicare and Medicaid. We also utilize a sliding fee scale for those who do not have insurance, or whose program does not accept their private insurance (PROSPER/PROS). All applicable fees (co-pays, co-insurance and sliding scale) are due at the time of the visit.

How long will I receive services?

- The length of the services depends on your individual treatment plan, which you and your primary clinician create together.

What if I forget to cancel an appointment or arrive late?

- If you are unable to attend an appointment (in-person or tele-behavioral health, we ask that you notify staff at least 24 hours in advance. If you are a "no-show" for an appointment or cancel late, you will be charged a fee of $25.00 (as applicable) for each missed appointment. If you are more than 15 minutes late for your appointment, it may be re-scheduled. Repeated missed appointments without proper notification or chronic lateness may result in a change of available services and/or a discharge from the program.

What if I want to change my primary provider at CoveCare Center?

- Consistency is very important when establishing a therapeutic relationship. Requests for a change in provider will be addressed on an individual basis to see how best to resolve the issue.
- We encourage all clients to discuss their expectations and any issues directly with their clinician if considering a change. Leaving a voice mail is an acceptable way to do this if discussing it directly seems too difficult. You may ask to speak to a supervisor at any time.

Are the services confidential?

- All services and records are confidential, as mandated by federal and state laws and HIPAA regulations. Protected Health Information (PHI) will not be released without your written consent.

  There are exceptions such as:
  - When child abuse/neglect is identified or suspected.
  - When you are in a state of emergency that necessitates disclosure of information to emergency personnel.
  - If you threaten to harm someone, the intended victim and the police will be notified.
  - When/if information is required through a valid court order or subpoena.
  - For recipients under the age of 18, informed consent will be obtained from the minor's parent/legal guardian in order to share any confidential information.

Are tele-behavioral health services available?

- CoveCare Center offers tele-behavioral health services for children and adults in our mental health and substance use treatment programs. A qualified mental health professional will assess the appropriateness and the child/adult preference for tele-behavioral health services. For children, feedback and preferences will be obtained from the appropriate family member. The clinician will also assess the ability of the caretaker to appropriately support the youth, to safely participate in sessions, and to follow up on treatment recommendations.
- The practitioner will be responsible for making the clinical determination that the client is appropriate for tele-behavioral health treatment. These considerations include, among other things: symptoms that could worsen with tele-behavioral health treatment (paranoid/delusions related to technology, etc.), medical issues, cultural and linguistic issues, suicidal or violent ideation, and client preference. The practitioner will be responsible for assessing whether the client should be accompanied by a staff member if at a CoveCare location during their tele-behavioral health encounters.
- Though telehealth affords flexibility, if you permanently relocate to another state or a significant distance from Putnam County, your worker will assist you in locating treatment and/or support services nearer to your place of residence. Temporary relocations will be assessed on a case-by-case basis.

What if I need paperwork completed by a CoveCare Center staff member?

- We receive numerous client requests for letters/paperwork, such as prior authorizations for medications, letters verifying participation in services, disability eligibility forms, etc. It is important that you allow 7-10 days for staff to accurately complete all the required information.
- Please note that documentation requesting functional capacity such as being able to perform certain job functions will be sent directly to the entity requesting the information with the proper signed consents. You may be asked to schedule an appointment with a provider to assess for functional capacity.

CoveCare Center
Mental Health Clinic Services

THERAPEUTIC AGREEMENT

CoveCare Center is dedicated to enhancing healing and growth in a responsive and dignified manner for residents of Putnam County and the surrounding areas. We carry out our mission to serve the community's mental health and substance use needs in accordance with regulations of our Office of Mental Health and Office of Alcohol and Substance Abuse licenses, Mental Hygiene Law and Regulation and other applicable state and federal laws.

The effectiveness of our interventions is dependent upon consistent attendance and active involvement in your services. As a non-profit agency, our survival depends upon serving people who are dedicated to their recovery and to paying all co-pays, co-insurances, and/or sliding scale fees. As a recipient of our services, you voluntarily enter into a therapeutic agreement that entitles you to the following rights and obligates you to the following responsibilities.

CLIENT RIGHTS

You have the right to:

- Receive an individualized plan of treatment services and to participate in the establishment and revision of that plan.
- Receive full explanations of the services provided in accordance with your treatment plan.
- Be informed of the program's rules and regulations.
- Receive considerate and respectful care.
- Receive services in such a manner to assure non-discrimination.
- Be treated in a way that acknowledges and respects your cultural environment.
- Receive confidential care. Except for life threatening emergency, court order, child abuse or crimes committed on program premises, the program cannot release information about your services without written consent. Minors over the age of 16 have their right to confidentiality unless their health or safety or the health and safety of others are in jeopardy. The confidentiality of clinical records shall be maintained in accordance with Section 33.16 of the Mental Hygiene Law.
- Obtain access to your clinical records consistent with Section 33.13 of the Mental Hygiene Law.
- Receive written/verbal education concerning the effects and possible side effects of any medication prescribed to you by CoveCare Center qualified staff.
- Be informed of the agency grievance procedures and to initiate any questions, suggestions, complaints, or objections accordingly.
- Obtain, in writing, an explanation of reason(s) for your discharge from services. When possible, you will receive a referral to another program. While your full participation in the program is a central goal, if you object to your individualized service plan or it is not working to your satisfaction and you want it changed, that alone is not a reason to discharge you from the program. You can be discharged if participation is no longer clinically appropriate or if you engage in conduct which poses a risk of physical harm to yourself or others.

- Be informed of other arrangements if your worker is not available.
- Freedom from abuse and mistreatment by employees.

Treatment in any outpatient program is voluntary. You can refuse or end recommended services at any time. You will be informed of any potential consequences to your health and well-being or due to any external mandates. External mandates refer to court ordered receipt of outpatient serves and assisted outpatient treatment. Involvement in child protection services may also recommend ongoing services.

CLIENT RESPONSIBILITIES

You have the responsibility to:

- Keep scheduled appointments or call at least 24 hours prior to the appointment if you cannot attend.
- Act in a responsible manner and observe the rules and regulations of the program.
- Treat staff and other clients with courtesy and respect.
- Respect other clients' right to confidential services.
- Participate in the development and completion of your treatment/service plan.
- Pay for services on at the time of the visit.
- Notify a staff member if your finances, insurance coverage, address, or phone changes.
- Talk to a staff member if you are thinking about ending your services with COVECARE CENTER or feel you need more/fewer intensive services.
- Ask questions about any aspects of your services you do not understand or are not comfortable with.
- Talk to a staff member about issues that may affect your services.
- All services within COVECARE CENTER conduct screenings on substance use and its impact on one's ability to function in key aspects of life, such as school, employment, and relationships with family and friends. As such, abstinence and/or a reduction in the use of mood-altering substances should be the focus of treatment, particularly in the Substance Use Program.

Communication between COVECARE CENTER and other mental health/medical, substance use providers is strongly encouraged. Communication and collaboration of care has proven to enhance recovery and improve the quality of one's life.

PAYMENT OF FEES

- COVECARE CENTER accepts most insurance, though some restrictions apply within specific programs. It is your responsibility to know your insurance coverage requirements regarding pre-approvals or if your insurance allows for tele-behavioral health services.
- All applicable fees are due at the time of visit.
- You must report any changes in insurance coverage in order to allow us to determine your benefits and fees.

- COVECARE CENTER offers a sliding scale fee for participants who do not have eligible insurance. In order to determine your fee, you must bring in documentation to verify your net income and number of dependents. We will also ask for verification of monthly expenses to assess a fair self-pay fee. Accepted documentation includes recent tax returns and pay stubs.
- If your financial situation changes, please resubmit documentation so that the fee can be revised.
- Any payment arrangements that are agreed upon must be in place before services can be received. If you refuse to pay for services rendered, services may be denied.

RULES AND REGULATIONS

The services we provide are confidential and presume voluntary participation. Please review the following Rules and Regulations. If you have any questions at this point or at any time during the assessment and treatment process, please ask your therapist or any available staff.

- No violence, verbal or physical abuse to other clients, workers, or property will be accepted.
- All applicable fees will be collected at the time of service unless alternate arrangements are made.
- All scheduled appointments are expected to be kept. A fee of $25 (as applicable) will be charged for "no-show" or late cancellations.
- The clinic reserves the right to suspend treatment if fee payments are not appropriately made.
- Involuntary discharges or grievances of any kind can be appealed to the Program Director and/or COVECARE CENTER compliance Officer.
- No use of alcohol, use or sale of illegal drugs, or any other forms of illegal activity may occur on COVECARE CENTER property.
- Clients who appear for appointments under the influence of alcohol or drugs will be assessed for safety but will not be seen for their scheduled appointment.
- No person shall have in his/her possession a weapon at CoveCare Center. Law Enforcement Officers shall be granted firearm exception while in the performance of official duties.

PRESCRIPTION POLICY

It is essential that you keep track of when you need refills for medication and ensure that you have a scheduled appointment with the physician before you run out. Refill requests will be addressed during standard business hours. Refill requests made after hours, weekends, and holidays will be evaluated on a case-by case basis to determine its urgency. CoveCare Center reserves up to 3 business days (10 days for mail order delivery) to review and complete any refill requests. Medications requiring a prior authorization may require additional time as insurance carriers have their own approval process independent from CoveCare Center.

COVECARE CENTER IS A TOBACCO/NICOTINE FREE FACILITY

COVECARE CENTER will ensure that all facilities and vehicles are "tobacco/nicotine free". No smoking on the grounds follows Putnam County regulations which state that smoking, including e-cigarettes, is prohibited within 30 feet of the building. The purpose is to protect employees, clients, interns, and visitors from the consequences of secondhand smoke.

- All clients, regardless of nicotine use history, will be offered education on the medical complications of nicotine use, dependence, and recovery. When applicable and if agreed to, nicotine cessation/reduction will be incorporated in individual treatment plans.
- To maintain a tobacco/nicotine free environment, all clients, family members, and other visitors are asked not to bring tobacco/nicotine products in the facility.
- Pamphlets and education material are available in the lobby.

CONSUMER ADVISORY COMMITTEE

Clients and family of clients are welcome to join the Consumer Advisory Committee to share your thoughts, ideas, and suggestions in order to improve services at CoveCare Center. The Committee meets quarterly in the evening. Please speak to your worker for more information.

WE NEED AND WELCOME YOUR INPUT!

If you have questions about the clinical services you receive at your program, please:

1. Talk to your worker. Most problems can and should be handles by your worker.
2. If the matter is not resolved, talk with his or her supervisor, the Program Director, or the Vice President of Behavioral Health Services.
3. If you feel your rights have been violated, you can also contact the Compliance Officer at: (845) 225-2700 ext. 159.
4. If you still have unresolved concerns, you may contact:

New York State Office of Mental Health
Customer Relations
(800) 597-8481

NYS Justice Center Vulnerable Person's Central Register
1-(855) 373-2122

National Alliance for the Mentally Ill (NAMI)
Putnam
(845) 363-1478

For individuals enrolled in substance use treatment:

NYS Office of Addiction and Support Services
Patient Advocacy
1-(800) 553-5790

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Health Screening Form

Client's Name: (Last)_____(First)_____ (MI)____
Gender: ☐Male ☐ Female ☐ Transgender Date of Birth: ____/_____/_____

Date of Last Physical Examination: ____/_____/_____ Height_____ Weight_____
Current Primary Medical Care Provider:
Name _____
Address _____

_____
Telephone Number _____

If you do not have a primary medical care provider, are you interested in getting help to obtain one? ☐No ☐Yes

Have the following changed in the last year? If Yes in what way has it changed?

Appetite ☐No ☐Yes _____
Weight ☐No ☐Yes _____
Sleeping Habits ☐No ☐Yes _____
Energy Level ☐No ☐Yes _____

Please indicate if you do the following. If yes how often?

Exercise ☐No ☐Yes _____
Drink Water ☐No ☐Yes _____
Drink Coffee/ Tea ☐No ☐Yes _____
Drink Energy Drinks ☐No ☐Yes _____
Drink Alcohol (including beer) ☐No ☐Yes _____
Use Drugs (including marijuana) ☐No ☐Yes _____
Smoke Cigarettes ☐No ☐Yes _____
Other Nicotine Products ☐No ☐Yes _____

If you use nicotine products please answer below:

Are there nicotine products in the home with younger children? ☐No ☐Yes
Are you interested in reducing or quitting nicotine? ☐No ☐Yes

Personal Medical History (select all) that apply

High Blood Pressure ☐No ☐Yes
High Cholesterol ☐No ☐Yes

Diabetes ☐No ☐Yes

Heart Attack ☐No ☐Yes

Stroke ☐No ☐Yes

Other Cardiac Condition ☐No ☐Yes

Pulmonary (Emphysema, COPD, Asthma) ☐No ☐Yes

Kidney Disease ☐No ☐Yes

Liver Disease (Cirrhosis, Hepatitis A/B/C) ☐No ☐Yes

Endocrine Condition (High or Low Thyroid, Pituitary Disease, Adrenal Disease) ☐No ☐Yes

Overweight	☐No ☐Yes	Traumatic Brain Injury	☐No ☐Yes
HIV/AIDS	☐No ☐Yes	Cancer	☐No ☐Yes
Tuberculosis	☐No ☐Yes	Mobility Impairment	☐No ☐Yes
Hearing Impairment	☐No ☐Yes	Visual Impairment	☐No ☐Yes

Other_____

Allergies (drugs, food, environmental): _____

Surgery(s) within the last 6 months-include dates:_____

Medication/Supplements (Please list all medications/supplements that you are currently taking. Include prescribed/non-prescribed drugs, vitamins and over- the- counter drugs, amount and frequency):

_____

_____

_____

Client Signature (If under 18 parent/ guardian must sign) _____Date____/____/____

Clinician Signature _____ Date____/____/____

Date Given To Nurse ____/____/____

Evaluation (To be completed by a physician, nurse practitioner, physician's assistant or registered professional nurse)

Staff Signature and Title _____ _____Date____/____/____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy Officer at 845-225-2700, x 159.

WE ARE COMMITTED TO YOUR PRIVACY

At CoveCare Center, we are committed to maintaining the privacy and confidentiality of your health information.

YOUR RIGHTS

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

You have the right to:

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.
- We may charge a reasonable, cost-based fee for either of the above services.

Ask us to amend your medical record.

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- If we say “no,” you can write a letter that explains your side of the story. We will add that letter to your medical record.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit the information we share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care or our ability to be reimbursed.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we have shared information.
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
- You can complain if you feel we have violated your rights by contacting us at 845-225-2700, x159 or by sending a letter to Privacy Officer, CoveCare Center, 1808 Route Six, Carmel, NY 10512.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

- Share Information with your family, close friends, or others involved in your care, if you do not object.
- Share information in a disaster relief situation.

You can indicate your choices by completing an authorization, commonly referred to as a consent.
This is especially important when you're asking us to share information about alcohol/drug treatment, mental health, or confidential HIV/AIDS-related treatment. The form enables you to specify individuals or entities with whom you want your information shared and specifically what information to share.

You have the right to revoke (withdraw) this authorization at any time except when we have already shared your information based on the consent you gave us.

- We will honor your verbal revocation request for a period of 2 weeks, but we must receive your written revocation, or we will proceed to share your information.
- You can choose to write us a letter specifying the information we can no longer share and the person, organization, facility, or program with whom we should no longer share.
- You can also use our Revocation of Authorization for Release of Information form on our website. Please be as specific as you can in writing your revocation. Indicate the name and address of the person(s) we are currently sharing this information with and include the date, or approximate date, you signed your authorization. Please address your written request to:

  CoveCare Center
  Medical Records
  1808 Route 6
  Carmel, NY 10512

- Your request won't be effective until we receive it and verify that you have provided the information we need to comply with your revocation request.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we won't share your information unless you give us written permission:
  - Marketing purposes.
  - Sale of your information.
  - Most sharing of psychotherapy notes.
- We may contact you for fundraising efforts, but you can tell us not to contact you again and we must comply with your request.

OUR USES AND DISCLOSURES

We typically use or share your health information for treatment, payment, and healthcare operations.

Treat You.
We can use your health information and share it with other professionals who are treating you.

Examples:
- *A doctor treating you asks another doctor about your overall health condition.*
- *We share information with a pharmacy that is filling your prescription.*

Bill for your services.
We can use and share your health information to bill and get payment from health plans or entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

Run our organization.
We can use and share your health information to run our business operations and the operations of our related treatment entities.

Example: We use health information about you to manage your treatment and services.

WE USE OR SHARE YOUR HEALTH INFORMATION TO CONTRIBUTE TO THE PUBLIC GOOD

We are allowed or required to share your information in other ways. Many of these contribute to the public good, such as public health and research. However, we must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues.
We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Conduct research.
We can use or share your information for health research.

Comply with the law.
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.
We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions.
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

WE SHARE YOUR INFORMATION TO ANALYZE OUR DATA AND IMPROVE SERVICES TO OUR CLIENTS

We will share your Protected Health Information with third party "business associates" that perform various activities for the agency. Whenever an arrangement between CoveCare Center and a business associate involves the use or disclosure of your Protected Health Information, we will have a written contract that contains terms that will protect the privacy of your Protected Health Information.

Your Protected Health Information may be accessed by participating providers in the Coordinated Behavioral Health Services Independent Practice Association (*cbhsinc.org)* when the participating providers have a treating relationship with you.

OUR RESPONSILITIES

Maintain privacy and security.
We are required by law to maintain the privacy and security of your protected health information.

Inform you if there is a breach.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Comply with this Notice.
We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

For More Information See:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

ACKNOWLEDGMENT OF RECIEPT AND CONSENT

We will ask you to sign a form stating that you have received this notice and you consent to the sharing of your information for treatment, payment, and health care operations. CoveCare Center may condition our treatment on your refusal to sign this consent.

Effective 2/1/22

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt and Consent for Treatment, Payment, and Business Operations

DATE: _____

I acknowledge that I was provided with a copy of the CoveCare Center Notice of Privacy Practices.

I am also aware that CoveCare Center will share my health information to:

- Arrange for my treatment
- Receive payment for the services provided to me
- Run CoveCare Center and improve the care provided to me

I consent to the sharing of my information for these purposes.

_____ _____

Client Name (Print) Client Signature

If completed by a client's personal representative, please print and sign your name in the space below. Please describe your authority as a personal representative

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Description of Personal Representative's Authority

Reviewed 2/1/22

HIPPA NOTIFICATION FOR COMMUNICATING WITH CLIENTS BY EMAILS AND TEXTS

You may ask us to communicate with you by email and/or text messages. CoveCare Center uses regular, unencrypted emails and texts. They're the same type of emails and texts we commonly receive and send on computers, laptops, tablets, and cellphones. They aren't protected by a technical process called encryption. Encrypted emails and texts are more secure.

There is some level of risk that information in unencrypted emails and texts sent by CoveCare Center could be read by someone other than you.

I have been notified that there is some level of risk that protected health information transmitted by unencrypted emails and texts could be read by someone other than me. I have indicated my preference for communicating with me below.

☐ **YES—You may communicate with me by email**. I am willing to accept the risks associated with CoveCare Center's unencrypted emails.

☐ **NO— Do not** communicate with me by email.

☐ **YES—You may communicate with me by text.** I am willing to accept the risks associated with CoveCare Center's unencrypted texts.

☐ **NO— Do not** communicate with me by text.

My email address is:

My phone number is:

Please inform us of any changes to your email address or phone number immediately.

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

Fagerstrom Test for Nicotine Dependence

	PLEASE TICK (✓) ONE BOX FOR EACH QUESTION	
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	☐ 3 ☐ 2 ☐ 1
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes No	☐ 1 ☐ 0
Which cigarette would you hate to give up?	The first in the morning Any other	☐ 1 ☐ 0
How many cigarettes a day do you smoke?	10 or less 11 – 20 21 – 30 31 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3
Do you smoke more frequently in the morning?	Yes No	☐ 1 ☐ 0
Do you smoke even if you are sick in bed most of the day?	Yes No	☐ 1 ☐ 0
	Total Score	
SCORE	1- 2 = low dependence 3-4 = low to mod dependence	5 - 7= moderate dependence 8 + = high dependence

Add up the scores from the questionnaire.

Information about scoring the Test is on the next page.

Scoring the Fagerstrom Test for Nicotine Dependence

To remind you of information (covered in Module 1) about scoring the Test:

Score of 1 - 2

A patient who scores between 1 and 2 on the Fagerstrom Test for Nicotine Dependence is classified as having a low dependence on nicotine. This suggests that they may not need Nicotine Replacement Therapy (NRT), although it is recommended that they still be monitored for withdrawal symptoms.

Score of 3-4

A patient who scores 3 or 4 would be considered to have a low to moderate dependence on nicotine and could be offered patches, inhaler, lozenges or gum. Please check NRT recommendations chart (insert link).

Score of 5-7

A patient who scores 4 would be considered to be moderately dependent on nicotine and can be offered patches, inhaler, lozenge or gum. They can also be offered the combined therapy of patches with lozenge and gum. Please check NRT recommendations chart (insert link).

Score of 8 and over

A patient who scores 5 and over would be considered highly dependent on nicotine and can be offered patches, inhaler, lozenges and/or gum. They can also be offered the combined therapy of patches and lozenges or gum. Please check the NRT recommendations chart (see the chart on the next page).

NRT recommendations chart

Dependence level	Nicotine Replacement Therapy Dosage	Combination Therapy
High	**Patches:** 21mg/24hr or 15mg/16hr **Inhaler:** 6 –12 cartridges per day **Lozenge:** 4mg **Gum:** 4mg	**Patches: 21mg/24hr or 15mg/16hr** AND **Lozenge or Gum: 2mg**
Moderate	**Patches:** 21mg/24hr or 15mg/16hr **Inhaler:** 6 –12 cartridges per day **Lozenge:** 4mg **Gum:** 4mg	**Patches: 21mg/24hr or 15mg/16 hr** AND **Lozenge or Gum: 2mg**
Low to moderate	**Patches:** 14mg/24hr patch or 10mg/16hr **Inhaler:** 6 –12 cartridges per day **Lozenge:** 2mg **Gum:** 2mg	**Patches: 14mg/24hr or 15mg/16hr** AND **Lozenge or Gum: 2mg**
Low	May not need NRT Monitor for withdrawal symptoms **Patches:** 7mg/24hr patch or 5mg/16hr **Lozenge:** 2mg **Gum:** 2mg	

Nicotine Replacement Therapy recommendations (from Clinical Guidelines – Part 7).

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PERMISSION TO TREAT A MINOR

Childs Name: _____ DOB: _____

I am the custodial parent/legal guardian of the above named child. I give permission for any of the CoveCare Center professional staff to provide behavioral health treatment to _____.

Signature Date

Print Name Relationship

Witness

CoveCare Center
Cancellation/Missed Appointment Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment no show/cancellation policy. This policy enables us to better utilize available appointments for our clients who are in need of immediate care.

Cancellation of an Appointment:

In order to be respectful of the needs of other clients and our clinicians trying to accommodate them, please be courteous and call the office promptly if you are unable to attend an appointment. This time may be reallocated to someone who is in urgent need of treatment and/or waiting for an available slot. If it is necessary to cancel your scheduled appointment, we require that you call **24 hours in advance from the time of your appointment.** Calling early in the day is appreciated. ***Appointments are in high demand, and your early cancellation will give another person the possibility of having access to timely care.***

How to Cancel Your Appointment:

To cancel appointments, please call **845-225-2700** and dial "0" for the receptionist. If you do not reach the receptionist you may leave a detailed message on the voice mail with your name, the name of the person whose appointment is being cancelled (if different from your own), and the time of the appointment being cancelled. If you would like to reschedule your appointment, please be sure to also leave us your phone number where you can be reached and let us know the best time to return your call.

No-Show Policy:

When someone misses an appointment without calling 24 hours in advance to cancel, it is considered a "No Show". Not giving such appropriate notice of cancellation impacts our ability to serve those individuals who need access to care in a timely manner. A failure to show up at the time of a scheduled appointment will be documented as a "no-show". The first time there is a "no-show" there will be no charge. Any additional "no-shows" will result in a fee of $25.00, as applicable, for each missed appointment.

If you have no shows for 3 appointments within a 3 month period, you may be asked to speak with a supervisor of the program prior to scheduling your next appointment.

Late Cancellations:

Cancellations that are made within 24 hours of an appointment are considered ***Late cancellations*** and will be considered as a "no-show". A fee of $25 will be assessed for appointments not cancelled prior to 24 hours of the appointment. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be charged a fee.

It is important you speak to your provider for assistance in keeping appointments on a regular basis.

Client Signature: _____ **Printed Name**: _____

Date: _____

Parent/ Guardian Signature: _____

Parent/ Guardian Printed Name: _____ **Date:** _____

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CoveCare Information Received upon Accessing Services

My signature below verifies that I have received the following information from CoveCare Center:

- Client Handbook which includes:
  - ✓ Therapeutic Agreement including Clients Rights and Responsibilities
  - ✓ Payment and Fees for services
  - ✓ Client responsibilities including rules and regulations
  - ✓ Explanation of After Hour Crisis Service
  - ✓ Office of Mental Health and/or Office of Addiction and Support Services Rights of Service Recipient
  - ✓ Tobacco Policy
  - ✓ Cancellation/ Missed appointment Policy
  - ✓ Prescription Policy

- Notice of HIPAA Privacy Practices Related to Protected Health Information

In addition, I was given the opportunity to ask questions and I know whom to contact if I have questions or concerns regarding this information.

Client's Signature Date

Print Name

NEW YORK STATE | Office of Addiction Services and Supports

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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

1. This authorization may include disclosure of all my health information, including where applicable, any and all information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT including CLINICAL RECORDS*, GENETIC, FAMILY PLANNING and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the entities indicated in Item 6.

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

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

4. Signing this authorization is voluntary. I understand that generally accessing services will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to whom this information will be Disclosed and Exchanged:

Cordant Health Solutions

6. Name and Address of Provider(s) releasing and exchanging information:

I authorize the provider(s) listed below to share my personal health information with the above listed Entity, (the Office of Addiction Services and Supports). So that the quality of the services I receive may be evaluated, I also consent to all necessary communications between the Office of Addiction Services and Supports and the following provider(s) relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services:

- Provider name and address: _____
- Additional provider names and addresses: _____

7. The Purpose of this disclosure is to allow authorized entities to communicate with the Office of Addiction Services and Supports to facilitate reporting.

8. My health information may be disclosed and exchanged for a period of two (2) years from the last date of service, or unless otherwise revoked.

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

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

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF REPRESENTATIVE AUTHORIZED BY LAW DATE

This form has been approved by the NYS Office of Addiction Services and Supports to permit release of health information. However, this form does not require health care providers to release health information.

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

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.