Telehealth Informed Consent

Today's Date: ________________

Medical Record #: ______________________

Client: ____ **Date of Birth:** ____________________

- **Consent to Telehealth Treatment:** I hereby consent to receive psychological/behavioral health assessment and/or treatment by Aspire Health Alliance via telehealth. I understand that telehealth includes the practice of care delivery, diagnosis, consultation, treatment, transfer of health information, therapeutic interventions, education, and other services using interactive audio, video, telephone, or data communications.
- **Confidentiality:** I understand that information about me will be kept confidential. I understand that records and information about me shall not be released without my consent or the consent of my authorized representative, except where the release is in accordance with applicable law. I understand the legal limitations on the confidentiality of my communications, including, without limitation, that disclosure may occur in certain circumstances in legal proceedings or to protect myself or others. The Aspire Health Alliance Notice of Privacy Practices further states Aspire Health Alliance obligations to protect your privacy.
- **Withdrawal from Telehealth Treatment:** I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- **Recommended Treatment Modality:** I understand that telehealth is not the recommended treatment modality for many clients including, but not limited to: clients who are actively suicidal or homicidal, clients with active substance abuse issues, clients with severe psychiatric conditions, clients in violent situations, etc. I understand that if telehealth services are not clinically indicated as appropriate, that I may be offered a treatment modality that will be better suited to my needs.
- **Right to Access:** I understand that I have the right to access my health information and copies of records in accordance with state laws.
- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

I acknowledge that I have read/had read and/or had explained to me all of the above and understand the guidelines to receive and continue telehealth services.

_________________________ ____

Date **Signature of Client/Legal Guardian**

____

If Signing for Client, please state relationship

2-WAY PROVIDER COMMUNICATION
Authorization To Use Or Disclose Protected Health Information

I hereby authorize the exchange of my/my child's/or ward's protected health information including my/my child's/or ward's psychiatric records between Aspire Health Alliance and/or the individual/organization named below. Disclosure may be by handwritten, electronic or verbal exchange.

Client Name	**Date of Birth**	**Medical Record Number**
Address (Street, City, State, ZIP Code)		Telephone Number

This information may be exchanged with and used by the following individual or organization.

Name: ____________________

Address: ____________________

Telephone: ____________________ Fax: ____________________

Treatment Dates: ***You Must Check***

☐ All Dates

☐ Specific Dates ____________________

Purpose of Request: ***You Must Check***

☐ Treatment ☐ Coordination of Care ☐ Personal

☐ Disability ☐ Insurance ☐ Legal

☐ Other Specify: ____________________

I authorize the disclosure of the following information which may be included in my record.

You Must Initial

____ Genetic Testing ____ Sexually Transmitted Diseases ____ Abortion

____ HIV Information ____ AIDS or AIDS Related Condition

____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2

I authorize the disclosure of the following information from my medical record.

You Must Check

Yes	**No**		**Yes**	**No**	
☐	☐	.... Discharge Summary	☐	☐	.... Medication Records
☐	☐	.... Treatment Plans	☐	☐	.... Psychological Testing Results
☐	☐	.... Consultations (including psychiatric evals)	☐	☐	.... Laboratory Results (including drug screenings)
☐	☐	.... Crisis Evaluations	☐	☐	.... History and Physical
☐	☐	.... Case Assessments	☐	☐	.... Physician Orders
☐	☐	.... Progress Notes	☐	☐	.... Complete Record
☐	☐	.... Billing Records	☐	☐	.... Other ____________________

☐ All checked items above, **excluding** the following: ____________________

____________________ **(Clients Initials)** ________

☐ Disclose **only** the specific information listed: ____________________

____________________ **(Clients Initials)** ________

2-WAY PROVIDER COMMUNICATION
Authorization To Use Or Disclose Protected Health Information

This information should be sent to the attention of ___________________________________ at the address indicated below:

☐ 1501 Washington Street
Braintree, MA 02184

☐ 639 Granite Street
Braintree, MA 02184

☐ 769 Plain Street, Unit I
Marshfield, MA 02050

☐ 64 Industrial Park Road
Plymouth, MA 02360

☐ 500 Victory Road
Quincy, MA 02171

☐ 460 Quincy Avenue
Quincy, MA 02169

☐ 2 Moon Island Road
Quincy, MA 02171

☐ 215 Sandwich Road, PO Box 31
Wareham, MA 02571

☐ South Shore Hospital (Bridge Clinic)
55 Fogg Road
Weymouth, MA 02190

☐ Other: ______________________
____
____

All questions should be directed to the Medical Records Department (617) 847-1941.

OTHER IMPORTANT INFORMATION

1. I understand that the Provider of the information disclosed cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Receipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality or Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider before the Provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Privacy Officer of Aspire Health Alliance at 500 Victory Road, Quincy, MA 02171.

3. Unless otherwise revoked, this authorization will expire on the following date, event, or condition or within one year:
____

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

Signature of Client or Legal Guardian	**Date**
If Signed by Legal Guardian, Relationship to Patient	

Office Use Only

Information Sent: ____

Date: ________________________________ By: _____________________________________

Original Copy to Client's medical record; copy to requester

PRIMARY CARE PHYSICIAN (PCP)
2-WAY PROVIDER COMMUNICATION
Authorization To Use Or Disclose Protected Health Information

Will you sign an authorization form allowing Aspire Health Alliance to share Protected Health Information (PHI) with your Primary Care Physician (PCP)?

Please check the appropriate box below:

☐ Yes, Please complete the authorization form below (BOTH SIDES) ☐ I do not have a PCP
☐ No, I do not want to share my/my child's/my wards's PCP

I hereby authorize the exchange of my/my child's/or ward's protected health information including my/my child's/or ward's psychiatric records between Aspire Health Alliance and/or the individual/organization named below. Disclosure may be by handwritten, electronic or verbal exchange.

Client:	DOB:	MR Number:
Address (Street, City, State, ZIP Code)		Telephone Number

This information may be disclosed to and used by the following individual or organization.

Name: ____

Address: ____

Telephone: ____________________ Fax: ____________________

Treatment Dates: ***You Must Check***

☐ All Dates

☐ Specific Dates ____________________

Purpose of Request: ***You Must Check***

☐ Treatment ☐ Coordination of Care ☐ Personal
☐ Disability ☐ Insurance ☐ Legal
☐ Other Specify: ____________________

I authorize the disclosure of the following information which may be included in my record.
You Must Initial

____ Genetic Testing ____ Sexually Transmitted Diseases ____ Abortion

____ HIV Information ____ AIDS or AIDS Related Condition

____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2

I authorize the disclosure of the following information from my medical record. ***You Must Check***

Yes	No		Yes	No	
☐	☐	.... Discharge Summary	☐	☐	.... Medication Records
☐	☐	.... Treatment Plans	☐	☐	.... Psychological Testing Results
☐	☐	.... Consultations (including psychiatric evals)	☐	☐	.... Laboratory Results (including drug screenings)
☐	☐	.... Crisis Evaluations	☐	☐	.... History & Physical
☐	☐	.... Case Assessments	☐	☐	.... Physician Orders
☐	☐	.... Progress Notes	☐	☐	.... Complete Record
☐	☐	.... Billing Records	☐	☐	.... Other ____________

☐ All checked items above, **excluding** the following: ______________________________
______________________________ **(Clients Initials)** ________

☐ Disclose **only** the specific information listed: ______________________________
______________________________ **(Clients Initials)** ________

PLEASE COMPLETE OTHER SIDE Page 1

PRIMARY CARE PHYSICIAN (PCP)
2-WAY PROVIDER COMMUNICATION
Authorization To Use Or Disclose Protected Health Information

This information should be sent to the attention of ______________________________ at the address indicated below:

☐ 1501 Washington Street
Braintree, MA 02184

☐ 639 Granite Street
Braintree, MA 02184

☐ 769 Plain Street, Unit I
Marshfield, MA 02050

☐ 500 Victory Road
Quincy, MA 02171

☐ 460 Quincy Avenue
Quincy, MA 02169

☐ 2 Moon Island Road
Quincy, MA 02171

☐ 64 Industrial Park Road
Plymouth, MA 02360

☐ 215 Sandwich Road, PO Box 31
Wareham, MA 02571

☐ South Shore Hospital (Bridge Clinic)
55 Fogg Road
South Weymouth, MA 02190

☐ Other: ________________________
____
____

OTHER IMPORTANT INFORMATION

1. I understand that the Provider of the information disclosed cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality or Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider before the Provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Privacy Officer of Aspire Health Alliance at 500 Victory Road, Quincy, MA 02171.
3. Unless otherwise revoked, this authorization will expire on the following date, event, or condition or within one year: ____

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

Signature of Client or Legal Guardian	**Date**
If Signed by Legal Guardian, Relationship to Patient	

Office Use Only

Information Sent: ____

Date: ______________________________ By: ___________________________________

Original Copy to Client's medical record; copy to requester

aspire health alliance

CLIENT PORTAL AUTHORIZATION

I hereby authorize the exchange of my/my child's/or ward's protected health information including my/my child's/or ward's psychiatric records and protected health infomation between Aspire Health Alliance and myself and/or the individual named below.

Client Name	Date of Birth	Medical Record Number
Address (Street, city, state, zip code)		Telephone Number
Treatment Dates (ALL DATES)		Purpose for Request: **PORTAL**

Please check one of the boxes below that best describes the portal access requested

Adult Client

Adult's Portal record.
(Note: This section also applies to Emancipated Minors. Emancipated Minors must provide proof of emancipation)

Select One:

☐ **Adult Client**

- The client should sign this form to provide authorization for release of their protected health information.
- Authorization for proxy access is valid until revoked by client and/or Aspire Health Alliance.

☐ **Legal Guardian of Adult Client:** Adults who have a legal guardian (court order)

- If you are the legal guardian for this client, then this request must be accompanied by a copy of the legal paperwork verifying your authority to have access to the client's medical information.
- You must notify Aspire Health Alliance immediately in case of any change in authority.

Minor Client

Access to your minor child's Portal record.

- Individuals requesting access must have parental rights or legal guardianship rights.

My Relationship to the child is:

☐ Parent ☐ Permanent Legal Guardian of the Client

- Must attach a copy of the Court Order Appointing Legal Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the client.
- You must notify Aspire Health Alliance immediately in case of any change in authority.

Select One:

☐ **Child Age 0-17:** You will be granted access to your child's portal until the child turns 18 years old and/or if access is revoked by parent/legal guardian and/or Aspire Health Alliance.

AUTHORIZATION:

- By signing this request, I understand that I am giving permission for Aspire Health Alliance to disclose my/my child's/or my ward's protected health information (PHI) through the Portal to myself and/or proxy.
- The information available to myself and/or proxy may include information relating to: Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Condition, Juman Immunodeficiency Virus (HIV), Genetic Testing, Sexually Transmitted Diseases, Mental or Behavioral Health or Psychiatric Care, Drug and Alcohol Abuse records or Abortion.
- I understand it is my responsibility to protect my privacy and security and will keep my login ID and password secure. I agree to notify the Aspire Health Alliance Privacy Officer if there is a change in my email account and/or the secure password has been breached.
- The request if effectie until my Portal account is inactivated by Aspire Health Alliance, myself or proxy.
- Portal access may include records that were created or existed on or before the date this form was signed, as well as records that are created after the date this form is signed.
- I understand that I may revoke this Portal Access in writing at any time, except that the revocation will not have any effect on any action take by the Provider before the Provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Privacy Officer of Aspire Health Alliance at 500 Victory Rd., Quincy MA 02171.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or State laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment.

By signing below, parents acknowledge and agree that:

- I have parental rights/legal guardianship rights to access this minor child's record.
- I have not been denied periods of physical placement wit the child and there are no court orders or restraining orders in effect limiting my access to this minor child's medical recoreds and/or protected health information.

By signing below, legal guardians acknowledge and agree that:

- Any documents I have provided in support of my right to access the protected health information, are true and correct copies and are the most recent documents related to this matter.
- When my legal authority to act on behalf of the client has been inactivated, revoked, terminated, or expired, I must immediately notify by contacting the Privacy Officer at Aspire Health Alliance.

____ **Signature of Client or Legal Guardian** ____ **Email Address:**	**Date:** ________________________
If signed by Legal Guardian, Relationship to Client: ____ ____ **Name: Last, First, Middle Initial** ____ **Address: Street Address, City, State, Zip Code**	
Office Use Only **Date PIN was issued:** __________________ **By:** ____	

IHT Family Therapy
Consent and Authorization

Today's Date: ________________

Medical Record #: ______________________

Client: ____ **Date of Birth:** ____________________

- **Consent to Treatment:** I hereby consent to receive psychological/behavioral health assessment and/or treatment by Aspire Health Alliance. This treatment may include any therapeutic interventions and/or other services provided by Aspire Health Alliance.
- **IHT Program Description:** I understand that IHT Intensive Family Therapy (IHT) is a service for MassHealth insured children (3-21 years) with significant social, emotional or behavioral challenges. This program delivers structured, strengths-based, collaborative therapeutic supports to an identified youth, and the youth's family with the purpose of treating the youth's behavioral health needs – from a family systems perspective. Interventions are designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for a youth's admission to an inpatient or other treatment settings.
- **Program Requirements:** I agree to participate in the following IHT program requirements:
  - ☐ Service frequency/intensity that supports IHT level goals – as recommended by my IHT therapy team
  - ☐ Weekly family therapy meetings with the entire family or small groups
  - ☐ Weekly parent support meetings to enhance and improve my capacity to improve my child's functioning
  - ☐ A weekly meeting schedule that exceeds outpatient therapy frequency; IHT meetings are typically held multiple times per week to offer the necessary supports to accomplish goals
  - ☐ Identification of community resources and natural supports to support my child and family
  - ☐ To remain actively engaged in treatment
- **Insurance Authorization:** I hereby authorize Aspire Health Alliance to release necessary information to my insurance carrier which may be required in order to secure payment for services to the above named client. This information will be considered confidential. I also authorize my insurance carrier to pay Aspire Health Alliance directly for services provided to the above named client.
- **Fee Agreement:** I have read and understand the Aspire Health Alliance Fee and Collection Procedure. I understand that Aspire Health Alliance will attempt to bill my insurance company, but if for any reason the service is not covered, I will be responsible for payment of that service at that rate. I will receive a __________ % discount of the published fee for each service to be provided and that I will be responsible to pay the remaining portion. I understand I will pay the amount due before the session on the day of my scheduled appointment. <u>I also understand that if I do not adhere to this agreement, services may be suspended.</u>

- **Confidentiality:** I understand that information about me will be kept confidential. I understand that records and information about me shall not be released without my consent or the consent of my authorized representative, except where the release is in accordance with applicable law. I understand the legal limitations on the confidentiality of my communications, including, without limitation, that disclosure may occur in certain circumstances in legal proceedings or to protect myself or others.
- **Notice of Privacy Practices:** I acknowledge that I have received a copy of Aspire Health Alliance's Notice of Privacy Practices. This describes how medical information about Aspire Health Alliance clients may be used and disclosed.
- **Patient's Rights:** I acknowledge receiving a copy of the Patient's Rights Notice.

I acknowledge that I have read/had read and/or had explained to me all of the above, including my responsibilities as a client of Aspire Health Alliance, as noted in the Notice of Patient's Rights.

_________________________ ____

Date **Signature of Client/Legal Guardian**

____

If Signing for Client, please state relationship

Therapeutic Mentoring Consent and Authorization

Today's Date: _______________

Medical Record #: ______________________

Client: ____ **Date of Birth:** ____________________

- **Consent to Treatment:** I hereby consent to receive psychological/behavioral health assessment and/or treatment by Aspire Health Alliance. This treatment may include any therapeutic interventions and/or other services provided by Aspire Health Alliance.
- **Therapeutic Mentoring:** I understand that Therapeutic Mentoring (TM) offers structured, one-to-one, strength-based support services between a Therapeutic Mentor and youth (up to the age of 21) to support specific goals on the child's behavioral treatment plan with their Outpatient or IHT Family Therapy provider. Goals include developing social and interpersonal skills, problem solving strategies, or daily living skills. Therapeutic Mentoring is designed to give children and teens the opportunity for skill building through experiences that would naturally occur in their everyday life by supporting goals in the community. To help the child develop a specified skill, their Therapeutic Mentor works to model, educate, motivate, and coach them on how to use and practice overcoming obstacles related to these skills.
- **Therapeutic Mentoring Program Requirements:** I agree to the following requirements for my child to remain active in this service:

  ☐ Child to have ongoing treatment with a "Hub" provider – Individual Therapist, IHT Family Therapist or Intensive Care Coordinator (ICC)

  ☐ To have regular consultation with the TM before/after meetings regarding my child's progress and any recommendations to support care

  ☐ To be available at all times when my child is brought into the community in case of emergency/need to return home earlier than expected
- **Insurance Authorization:** I hereby authorize Aspire Health Alliance to release necessary information to my insurance carrier which may be required in order to secure payment for services to the above named client. This information will be considered confidential. I also authorize my insurance carrier to pay Aspire Health Alliance directly for services provided to the above named client.
- **Fee Agreement:** I have read and understand the Aspire Health Alliance Fee and Collection Procedure. I understand that Aspire Health Alliance will attempt to bill my insurance company, but if for any reason the service is not covered, I will be responsible for payment of that service at that rate. I will receive a __________ % discount of the published fee for each service to be provided and that I will be responsible to pay the remaining portion. I understand I will pay the amount due before the session on the day of my scheduled appointment. I also understand that if I do not adhere to this agreement, services may be suspended.

- **Confidentiality:** I understand that information about me will be kept confidential. I understand that records and information about me shall not be released without my consent or the consent of my authorized representative, except where the release is in accordance with applicable law. I understand the legal limitations on the confidentiality of my communications, including, without limitation, that disclosure may occur in certain circumstances in legal proceedings or to protect myself or others.
- **Notice of Privacy Practices:** I acknowledge that I have received a copy of Aspire Health Alliance's Notice of Privacy Practices. This describes how medical information about Aspire Health Alliance clients may be used and disclosed.
- **Patient's Rights:** I acknowledge receiving a copy of the Patient's Rights Notice.

I acknowledge that I have read/had read and/or had explained to me all of the above, including my responsibilities as a client of Aspire Health Alliance, as noted in the Notice of Patient's Rights.

___________________________ ____

Date **Signature of Client/Legal Guardian**

____

If Signing for Client, please state relationship

HEALTH AND MEDICATION HISTORY

Date: ________________

Client: ____ **MR#:**_________________________________

Date of Birth: ________________ **Form Completed By:** ____

MEDICAL HISTORY (Please indicate if you still have the medical condition and the dates diagnosed)

Diagnosis	Date Diagnosed	Current Issue	Treatment Doctor	Comments
Diabetes				**Type:**
High Blood Pressure				
High Cholesterol				
Hypothyroidism				
Hyperthyroidism				
Goiter				
Cancer				**Type:**
Leukemia				
Psoriasis				
Heart Problems				**Specify:**
Angina				
Asthma				
COPD				
Stroke				
Epilepsy				
Cataracts				
Kidney Disease				
Kidney Stones				
Crohn’s Disease				
Colitis				
Anemia				
Jaundice				
Hepatitis				
Stomach or Ulcer				
HIV/AIDS				
Tuberculosis				
Rheumatic Fever				
GERD				
Gynecological Disease				
Arthritis				
Sleep Apnea				
Immune Disorder				
Other:				

PLEASE COMPLETE OTHER SIDE PAGE 1

HEALTH AND MEDICATION HISTORY

Substance Use:

Alcohol: ☐ Current ☐ Past ☐ Never ☐ Number of drinks per week: ______

Recreational Drug Use: ☐ Current ☐ Past ☐ Never ☐ Type: ___________________________

Please list all medications that you are currently taking including over the counter drugs.

Medication	Dosage	Prescriber

CURRENT PROVIDERS:

Primary Care Physician's Name	Address (Street, City, State, Zip Code)	Phone Number	Date Last Seen

Other Outside Provider's Name	Address (Street, City, State, Zip Code)	Phone Number	Date Last Seen

ALLERGIES:

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Collaborative Helping MAP

Family Vision

Where would you like you family to be headed in your lives?

1. Describe vividly the kind of family you want to live in – what does it look like/sound like/feel like?
2. Think of a happy time in your life and describe it to me.
3. Ask the miracle question: *"If you woke up one morning and overnight everything would have miraculously turned perfect, what would life in your family look like?"*
4. Prompts to address family functioning: *"What would you like to be able to do as a family that you don't or can't do now?"*
5. Prompts to address individual functioning: *"What would you like to be able to do (or your child to be able to do) that you don't do now?"*
6. How would you like your children to behave?
7. How would you like your partnership to be (co-parenting)?
8. Prompt for clinician to reframe an individual focus to a family systems perspective – clinician should observe interactional patterns in a family systems context, describing actions and reactions, while avoiding blame and recognizing that all family members are doing the best they can in the moment.

Obstacles/Challenges

What gets in the way?

- MH issues
- Limiting beliefs
- Finances
- Family systems issues/stuck interactional patterns
- Dilemmas/catch 22s
- Issues of race, culture, socioeconomic status, etc.
- Long working days
- Ambivalence

Supports

What helps you get there?

- Formal education/support groups
- Identify natural support network – family, friends, religious institution, neighbors, etc.
- Individual qualities and family strengths
- Personal attitude/attitude of taking responsibility, determination
- Sustaining beliefs and habits
- Dreams, hopes, values

Plan

How can IHT help you get to where you want to go? What needs to happen next?

- Referrals needed – plan for waitlist time.
- Information or resources needed.
- Differentiate clearly what IHT can/cannot do and what the family can/cannot do.
- "How will you know that IHT is ready to close?"

Family Vision

Where would you like your family to be headed in your lives?

Obstacles/Challenges

What gets in the way?

Supports

What helps you get there?

Plan

How can IHT help you get to where you want to go? What needs to happen next?

aspire health alliance

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003
Revised: 10/1/10, 11/1/12, 09/23/13, 09/30/13, 1/30/17, 12/11/18

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 our Privacy Officer at (617) 774-1080.

INTRODUCTION

This Notice of Privacy Practices ("Notice") describes how Aspire Health Alliance may use and disclose your protected health information ("PHI") to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice applies to the privacy practices of all Aspire Health Alliance locations. This Notice also describes your rights regarding the PHI we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your privacy and your rights regarding your PHI.

PROTECTED HEALTH INFORMATION

"Protected Health Information" (PHI) means health information, including identifying information about you, that we have collected from you or received from your health care providers, health plans, your employer or a health care clearinghouse. It may include any information about your past, present or future physical or mental health or condition, the provision of your health care, and payment for your health care services.

OUR RESPONSIBILITIES

Aspire Health Alliance is committed to respecting your privacy and confidentiality. We are required by law to maintain the privacy of your PHI and to provide you with this Notice. We are also required to comply with the terms of our current Notice. We will post a copy of the current Notice at our main office and at each of our sites where we provide care. You may also obtain a copy of the current Notice on our website at *www.aspirehealthalliance.org* or by calling Aspire Health Alliance.

I. HOW WE MAY USE AND DISCLOSURE YOUR PHI

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

A. Treatment

We may use or disclose your PHI to manage, coordinate, and provide your health care treatment and any related services. For example, Aspire Health Alliance may disclose information to the Aspire Health Alliance team members involved in managing and providing your care, including treatment providers, social workers, and other health care personnel or to other health care providers outside of Aspire Health Alliance. Further, your therapist may discuss your care with his or her supervisor.

B. Payment

We may use or disclose your PHI for billing and payment purposes. For example, we may disclose your PHI to your insurer or health plan for a number of reasons, including: to obtain approval of services; to determine eligibility or coverage for health insurance; to review whether your services were medically necessary; to review whether your services were appropriately authorized or certified in advance of your care; or to review your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

C. Health Care Operations

We may use and disclose your PHI for our health care operations. These uses and disclosures are necessary to operate our agency and make sure that you receive quality care. These activities may include quality assessment and improvement, quality management, reviewing the performance or qualifications of our management, clinicians, training students in clinical training activities, licensing, and accreditation, business planning and development, fundraising and general administrative activities. We may combine the PHI of our clients to decide what additional services we should offer, what services are no longer needed, and whether certain new treatments are effective. We may also combine our PHI with PHI from other providers to compare how we are doing and see where we can make improvements in our services. When we combine our PHI with information of other providers, we will remove identifying information so it may be used to study health care or health care delivery without identifying specific clients.

D. Business Associates

Some services, including but not limited to electronic data and medical records storage, may be performed on Aspire Health Alliance's behalf by third party contractors called business associates. Business associates are required to safeguard your PHI properly.

E. Opportunity to Object

Persons Involved in your Care. In limited circumstances, we may use and disclose your PHI without your authorization, but you will have an opportunity to object. For example, we may disclose your PHI for the purpose of collecting payments from someone who helps pay for your care. In such case, you would have an opportunity to object.

Appointment Reminders. We may contact you via voice or text messages to remind you of your scheduled appointments, using the telephone number that you have provided to us. While these appointment reminders can be useful, they may also pose a risk to you. For example, a family member might answer your home telephone or listen to a reminder message left on your answering machine. Text messages sent to your mobile phone are not secure and may be read by anyone who uses your mobile phone. You may possibly incur a charge from your cellular carrier for receiving our text message, or the message may count against your plan limit. Every appointment reminder message you receive from us will contain instructions on opting out of receiving future reminder messages. You may also opt out of these appointment reminders by contacting our Privacy Officer at (617) 774-1080.

Fundraising. We may contact you as part of our fundraising efforts. You have the right to opt out of receiving such communications. Any fundraising material sent to you will include a description of how you may opt out of receiving such communications. If you opt out, we will use best efforts to make sure that you do not receive any further fundraising solicitations.

II. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Aspire Health Alliance may legally use and disclose your PHI to others for certain purposes that are not treatment, payment or health care operations, without your written authorization or opportunity to object. Such examples include but are not limited to the following:

Facility Directory. We do not maintain a facility directory at any of our outpatient programs. If asked, we will not confirm that you are our current or former client, verbally, in writing, or through any other means. Exceptions are listed below under "Person's Involved in Your Care."

Persons Involved in Your Care. We may provide health information about you to someone who helps pay for your care as required for the purposes of collecting payment.

A. Emergencies

If you are in an emergency situation, we may disclose your PHI to a spouse, a family member, or a friend so that such person may assist in your care. In this case we will determine whether the disclosure is in your best interest, and if so, only disclose information that is directly relevant to the emergency. PHI may be disclosed to other healthcare providers in the event that emergency psychiatric treatment is required.

B. Unable To Make Health Care Decisions

In non-emergency situations where you are unable to make your own health care decisions, we will, under certain circumstances and as authorized by law, disclose your PHI to an authorized health care proxy, guardian or applicable state agency responsible for consenting to your care.

C. As Required By Law

We will disclose PHI about you when required to do so by federal, state or local law.

D. To Prevent a Serious Threat to Health or Safety

We may use and disclose your PHI when necessary to prevent a serious and imminent threat to the health or safety of you, the public or another person. Under these circumstances, we will only disclose PHI to someone who is able to help prevent or decrease the threat.

E. Public Health Activities

We may disclose PHI about you as necessary for public health activities, including, by way of example, for the purpose of:

- reporting to public health authorities if required by law for the purpose of;
- preventing or controlling disease, injury or disability;
- conducting public health surveillance or investigations;
- reporting child abuse or neglect;
- reporting to the Food and Drug Administration
- (FDA) or to a person required by the FDA to report certain events including information about defective products or problems with medications;
- notifying consumers about FDA-initiated product recalls; and;
- notifying appropriate government agencies if we believe you have been a victim of abuse, neglect or domestic violence.

F. Health Oversight Activities

We may disclose PHI about you to a health oversight agency for activities authorized by law. Oversight agencies may include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, and other government programs regulating health care and civil rights laws.

G. Disclosures in Legal Proceedings

In limited circumstances, and as authorized by law, we may disclose your PHI to a court or other administrative tribunal.

H. Law Enforcement Activities

We may disclose your PHI to a law enforcement official for law enforcement purposes in limited circumstances as authorized by law.

I. Medical Examiners or Funeral Directors

We may provide PHI about you to a medical examiner and/or funeral directors according to law. Medical examiners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances.

J. National Security and Protective Services for the President and Others

We may disclose medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

K. Workers Compensation

We may disclose PHI about you to comply with the Massachusetts Workers' Compensation Law.

III. USES OR DISCLOSURES OF PHI THAT REQUIRE YOUR WRITTEN PERMISSION

Uses and disclosures of your PHI not otherwise described in this Notice will require your written permission, called an "authorization." Examples of uses and disclosures that require your authorization include, but are not limited to, most disclosures of psychotherapy notes, drug and alcohol abuse treatment records, and disclosing for marketing purposes. Further, Aspire Health Alliance is prohibited from selling your PHI without your express written authorization. You have the right to revoke your authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your PHI, unless we have already taken action relying upon the uses or disclosures you have previously authorized.

IV. YOUR RIGHTS REGARDING YOUR PHI

A. Right to Inspect and Copy

You have the right to request an opportunity to inspect or copy your PHI used to make decisions about your care – whether they are decisions about treatment or payment. You must sign an authorization form and submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and supplies associated with your request.

We may deny your request to inspect or provide you with a copy of your PHI in certain limited circumstances. If your request is denied, you may, in some circumstances, request that the information be sent directly to another health care provider or your attorney.

B. Right to Amend

For as long as we keep records about you, you have the right to request us to amend any PHI used to make decisions about your care - whether they are decisions about treatment or payment. You must submit a request in writing to our Privacy Officer and tell us why you believe the information is incorrect or inaccurate. We may deny

your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend PHI that:

- was not created by us;
- is not part of the PHI we maintain to make decisions about your care;
- is not part of the PHI that you would be permitted to inspect or copy; or
- is accurate and complete.

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

C. Right to an Accounting of Disclosures

You have the right to request that we provide you with an accounting (list) of disclosures we have made of your PHI, other than those we have made for purposes of treatment, payment, and health care operations except as specified herein. To request an accounting of disclosures, you must submit your request in writing. For your convenience, you may submit your request on a form called a "Request For Accounting," which you may obtain from Aspire Health Alliance. The request should state the time period for which you wish to receive an accounting. You may request an accounting as far back as six years, except requests for electronic disclosures relating to treatment, payment or health care operations are limited to three years. The accounting will not include (i) non-electronic disclosures relating to treatment, payment or health care operations; (ii) disclosures if you gave your written authorization to share the information; (iii) disclosures shared with individuals involved in your care; (iv) disclosures to you about your health condition; (v) disclosures made for national security or intelligence purposes or to correctional institutions or law enforcement officials who have custody of you. We will respond to your request within 60 days of receiving it. The first accounting you request within a twelve-month period will be free. For additional requests during the same 12 month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request at that time.

D. Right to Request Restrictions

You have the right to request a restriction on the PHI we use or disclose about you to others who are involved in your care or payment, like a family member or friend. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted PHI is needed to provide you with emergency treatment.

E. Right to Restrict Disclosures

You have the right to restrict certain disclosures of PHI to a health plan if you pay out-of-pocket in full for the health care item or service.

F. Right to Request Confidential Communications

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

G. Breaches

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

V. CONFIDENTIALITY OF SUBSTANCE ABUSE RECORDS

For clients who receive treatment, diagnosis or referral for treatment from our drug or alcohol abuse programs, the confidentiality of drug or alcohol abuse records is protected by state and/or federal law. As a general rule, we may not tell a person outside the programs that you attend any of these programs, or disclose any information identifying you as a substance abuser, unless: you authorize the disclosure in writing; the disclosure is permitted by a court order; the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation purposes; you threaten to commit a crime either at the drug or alcohol abuse program or against any person who works for Aspire Health Alliance's drug or alcohol abuse programs.

A violation of the federal law governing drug or alcohol abuse may be a crime. Suspected violations may be reported to the Unites States Attorney in the district

where the violation occurs. Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities. See 42 U.S.C. 290dd–3 and 42 U.S.C. 290ee–3 for federal laws and 42 CFR Part 2 for federal regulations.

Record Retention

Aspire Health Alliance's clinical records are maintained for 20 years after the client's discharge or after the final treatment, as otherwise required by law. All non-clinic Aspire Health Alliance records will be maintained according to law and/or as specified in the contract with the vendor.

Changes to This Notice

We reserve the right to change the terms of this Notice. We also reserve the right to make the revised or changed Notice effective for PHI that we already have about you as well as any PHI we receive in the future. We will post a copy of the current Notice of Privacy Practices at our main office and at each of our sites where we provide care. You may obtain a copy of the current Notice of Privacy Practices on our website at *www.aspirehealthalliance.org* or Aspire Health Alliance.

Right to a Paper Copy of this Notice

You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice of Privacy Practices electronically, you may still obtain a paper copy. To obtain a paper copy, contact our *Privacy Officer.*

Right to File a Complaint

You have the right to file a complaint if you believe your privacy rights were violated by Aspire Health Alliance. Your care will not be affected if you file a complaint. You may file a complaint by contacting the Privacy Officer listed below.

Privacy Officer
Aspire Health Alliance
500 Victory Road
Quincy, MA 02171

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, at (800) 696-6775 or email ocrmail@hhs.gov.

You may contact our Privacy Office for further questions regarding Aspire Health Alliance's privacy practices.

NOTICE OF PATIENTS' RIGHTS

Your Rights Are:

1. You have the right to be treated with courtesy, respect, and dignity.
2. You have the right to receive the highest quality of care.
3. You have the right to receive care in a place free of architectural barriers if you have a limiting physical condition, and without regard to race, sex, religious affiliation, ethnicity, or sexual preference.
4. You may request at any time the name and specialty of the person who is responsible for the program that is providing your service and how (s)he may be contacted.
5. You have the right to ask and know about the qualifications of the people who are helping you, and the qualifications of those responsible for your care.
6. You have the right to privacy during treatment within the capacity of Aspire Health Alliance.
7. You have the right to confidentiality of the information shared to the extent provided by law. In clinics providing alcohol and drug treatment, you have the right to confidentiality of the alcohol and drug treatment records maintained by the program which is protected by Federal law and regulations 42 CFR, Part 2. Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

There are certain situations in which we will reveal information:

- with your written permission;
- to protect the safety of yourself and others when required by law;
- to courts in certain legal proceedings;
- incidents regarding abuse of children, elderly persons or disabled persons when required by law;
- to accreditation bodies, state funding agencies and third party payers conducting required record reviews;
- to authorized supervisory staff and quality of care reviewers at Aspire Health Alliance for treatment planning purposes and coordination of care among Aspire Health Alliance staff and/or authorized consultants;
- according to law.

8. You have the right to a prompt and adequate response to reasonable requests made within the capacity of Aspire Health Alliance.
9. You have the right to be informed and to give consent to the risks and possible side effects of any medication and treatments prescribed by professional staff.
10. You, and/or your guardian, and your service provider will review your treatment plan periodically. You have the right to ask your Service Provider or the Program Director for a re-evaluation or consultation with another service provider. You have the right to receive information necessary to give informed consent prior to the start of any treatment. You also have the right to be informed of any alternative treatment or procedures that may be available to you. In Department of Mental Health/Department of Mental Retardation funded programs, you have the right to appeal your treatment plan to their Area Office.

11. You have the right to request to inspect your record and to request a copy of your record (for a reasonable fee, if applicable), thereof in accordance with Massachusetts General Law, Chapter 111, Section 70E. Requests should be addressed to your Service Provider and the Program Director in writing. A signed Authorization Form is required for requests for copies of your record.

12. You, and/or your guardian must give informed consent before being involved in an experimental procedure or research study conducted by Aspire Health Alliance or any other agency associated with Aspire Health Alliance. You have the right to know the qualifications of the researchers, any risks that may be involved, and you have the right to refuse to participate without jeopardizing your care in the programs.

13. You have the right to refuse to be observed, examined, or treated by students or any other facility staff without jeopardizing your care in the programs.

14. You will receive an explanation of the basis on which your fee is set. The current fee schedule is available to you upon request and is posted in the outpatient service area.

15. If you wish to be referred to another agency or practitioner, every effort will be made to refer you to the most appropriate resources.

16. You have the right to freedom of choice to select a facility, a physician, or health service mode, except in the case of emergency medical treatment or as otherwise provided for by contract, or except in the case of a patient or resident of a facility named in Massachusetts General Law, Chapter 19, Section 14; provided, however, that the physician, facility, or health service mode is able to accommodate the patient exercising such right of choice.

17. You have the right, upon request, to receive a copy of an itemized bill or other statement of charges submitted to any third party by Aspire Health Alliance for your care and to have a copy of the itemized bill or statement sent to your attending practitioner.

18. You have the right, upon request, to receive an itemized bill including third party reimbursements paid toward your bill, regardless of the sources of payment.

19. You have the right, upon request, to obtain an explanation as to the relationship, if any, of Aspire Health Alliance to any other health care facility or educational institution insofar as this relationship relates to your care or treatment.

20. You have the right, upon request, to obtain an explanation as to the relationship, if any, of your practitioner to any other health care facility or educational institutions insofar as this relationship relates to your care or treatment. This explanation will include your practitioner's ownership or financial interest, if any, in the facility or other health care facilities insofar as this ownership relates to your care or treatment.

21. You have the right to prompt lifesaving treatment in an emergency without discrimination due to economic status or source of payment, and without delaying treatment for purposes of prior discussions of the source of payment, unless such delay can be imposed without material risk to your health. This right shall also extend to those persons not already patients or residents of a facility if said facility has a certified emergency care unit.

22. You have the right, if refused treatment because of economic status or the lack of a source of payment, to prompt and safe transfer to a facility which agrees to receive and treat you. Said facility refusing to treat you shall be responsible for contacting a facility willing to treat you; arranging the transportation; accompanying you with necessary and appropriate professional staff to assist in the safety and comfort of the transfer; assuring that the receiving facility assumes the necessary care promptly; and provision of pertinent medical information about your condition and maintaining records of the foregoing.

23. In our attempt to provide the highest possible quality of care, we engage regularly in program evaluation procedures. If you are contacted regarding a program evaluation, you have the right to refuse to participate without affecting your treatment.

24. You have the right to ask for a copy of any rules or regulations which apply to your conduct as a patient or resident.

25. You have the right, upon request, to ask for information pertaining to financial assistance and free health care.

26. In the case of a patient suffering from any form of breast cancer, you have the right to complete information on all alternative treatments which are medically viable. Except in cases of emergency surgery, at least ten days before a physician operates on a patient to insert a breast implant, the physician shall inform the patient of the disadvantages and risks associated with breast implantation. The information shall include, but not be limited to, the standardized written summary provided by the department. The patient shall sign a statement provided by the department acknowledging the receipt of the standardized written summary. Nothing shall be construed as causing any liability of the department due to any action or omission by the department relative to the information provided pursuant to this right.

27. In the case of a maternity patient, at the time of pre-admission, you have the right to complete information from an admitting hospital on its annual rate of primary caesarean sections, annual rate of repeat caesarean sections, the annual rate of total caesarean sections, the annual percentage of women who have had a caesarean section who have had a subsequently successful vaginal birth, the annual percentage of deliveries in birthing rooms and labor delivery-recovery rooms or labor-delivery-recovery-post-partum rooms, the annual percentage of deliveries by certified nurse-midwives, the annual percentage which were continuously externally monitored only, the annual percentage which were continuously internally monitored only, the annual percentage which were monitored both internally and externally, the annual percentage utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinals, epidurals and general anesthesia, and the annual percentage of women breast-feeding upon discharge from said hospital.

28. A facility shall require all people, including students who examine, observe or treat a client, to wear an identification badge which readily discloses their first name, their licensure status, if any, and their staff position.

"Any person whose rights under this section are violated may bring, in addition, to any other action allowed by law or regulation, a civil action under sections 60B to 60E, inclusive, of chapter two hundred and thirty-one.

No provision herein shall apply to any institution operated by and for persons who rely exclusively upon treatment by spiritual means through prayer for healing, in accordance with the creed or tenets of a church or religious denomination or patients whose religious beliefs limit the forms and qualities of treatment to which they may submit.

Provision herein shall be construed as limiting any other right or remedies previously existing at law."(Massachusetts General Law, Chapter 111, Section 70E)