IHT Intake Packet

Forms Included in the Packet

1. CANs Consent
2. Telehealth Informed Consent
3. IHT Family Therapy Consent and Authorization
4. 2-Way Provider Communication Authorization
5. 2-Way PCP Communication Authorization
6. Client Portal Authorization
7. ROI to Insurance Provider
8. Health and Medication History
9. Technology Agreement
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Executive Office of Health and Human Services
Office of Medicaid (MassHealth)

Permission to Get and Share Information in the MassHealth Child and Adolescent Needs and Strengths (CANS) System

Name of MassHealth member (Member): _____

Name of behavioral-health assessor (Assessor): _____

Name of provider organization (Provider): _____

Provider address: _____

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

What is the CANS?

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

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

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

Why MassHealth Wants to Obtain and Share CANS Information

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

If you give your permission, the Provider noted above will enter any CANS information that it collects about the Member into the MassHealth system. Through this system, MassHealth will be able to access such information and make it available to the Provider for future access. MassHealth will also use the system to give the Provider access to any CANS information entered by the Member's other providers. This will allow the Provider to update the Member's CANS information when needed, rather than redoing the whole CANS again. If you agree, MassHealth will also use the system to give the Member's other providers with permission access to the CANS information entered by the Provider in the CANS system, so they will understand the Member's history and may not need to ask the Member to repeat as much information. Your permission will also allow MassHealth to use the system to give a MassHealth managed-care entity in which the Member is enrolled access to CANS information collected by the Provider.

Your Permission

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

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

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

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

Things You Should Know

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

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

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

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

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

The written cancellation must:

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

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

Your Signature

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

Printed name of person signing permission: _____

Signature of person signing permission: _____

Date of signing (date permission starts): _____

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

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

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

☐ I am the Member's custodial parent.

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

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

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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

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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. 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

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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)** _____

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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

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

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2-WAY PROVIDER COMMUNICATION (PCP)

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)** _____

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2-WAY PROVIDER COMMUNICATION (PCP)

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

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

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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	Minor 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.	**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:** _____

Release of Information to Insurance Provider

I hereby authorize Aspire Health Alliance to disclose my/my child's/or ward's medical records including psychiatric records to my insurance provider. I understand I may be billed for the services provided if I do not allow my insurance provider to have access to my/my child's/or word's medical records.

Client Name	Date of Birth	Medical Record #

Address (Street, Apt., City, State, Zip Code)

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

Name: My/My child's/Ward's Insurance Provider _____

Address: _____

Treatment Dates: All Dates	**Purpose of Request:** Insurance Request

You Must Check and Initial

☐ _____ I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by Federal Regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111§70, such information will be included in this disclosure. If you **do not** wish to release any of the categories of information described above, please specify: _____

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 event: **This Authorization will expire within 1 year of discharge from Aspire Health Alliance**.
4. 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.
5. I understand that I may be charged a fee for the reproduction of the requested health information. This fee will comply with Massachusetts Law Chapter 111: Section 70 with regard to the inspection and copying of medical records.
6. If I have any questions about disclosure of my health information, I can contact Aspire Health Alliance's Medical Records Department at (617) 847-1941. Completed form can be faxed to (617) 774-1490 or mailed to Aspire Health Alliance, Medical Records Department, 500 Victory Road, Quincy, MA 02171.

Signature of Client or Legal Guardian: _____ **Date:** _____

If Signed by Legal Guardian, Relationship to Patient: _____

Due to COVID 19, Parent/Guardian gave verbal consent. ☐ Yes ☐ No

Signature of Clinician: _____ Date: _____

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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

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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:

Communication via Technology Agreement for Clients

Communication with Aspire clinicians and staff are different from texting or emailing others in your life. We always want to keep your information confidential, secure and safe. The information below reflects this goal and allows you to know your information is safe.

Texting

- We may use texting to schedule, confirm, and/or cancel appointments through our Aspire phone system.
- We do not use texting to have conversations about your health or personal information, because texting is not a secure method to communicate and because we believe these types of conversations are more effective in person, on the telephone or through video telehealth.

Email

- We may use email to communicate with you about appointment times and email a link for your appointment if you are receiving telehealth services. We may also send you a link through a secure portal that will allow for you to electronically sign Aspire documentation.
- We do not use email to have conversations about your health or personal information, because we believe these types of conversations are more effective in person or on the telephone.

Facebook, Instagram and other online networking sites

Aspire employees are not allowed to accept "friend" requests from persons served or to engage in personal online relationships.

If you are experiencing a Behavioral Health Emergency

- If you are experiencing a behavioral health emergency, please follow your emergency procedures. If you have questions about that procedure, please ask your Aspire provider. Alternatively, you may call the Massachusetts State Behavioral Health Emergency Number at **(877) 382-1609** to get information regarding the behavioral health emergency service provider in your area.

Answering your email or text – What you should expect from your provider

- The Aspire provider may not see or be able to acknowledge receiving your text or email on the day you sent the message and you may need to wait until the next business day they are in the office.

I acknowledge that I have read and/or had explained to me all of the above, including my responsibilities as a client of Aspire Health Alliance.

_____

Client signature (Date)

_____

Guardian's signature (if applicable) (Date)

NOTICE OF PRIVACY PRACTICES

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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.