LUTHERAN SOCIAL SERVICES
OF NORTHWESTERN OH
INFORMATION FORM

For Office use only:

☐ 100 Individual Counseling Assigned Worker _____ Case Number: _____

☐ 110 Family Counseling Assignment Date _____ Office: _____

☐ 135 SUD Only Date of Beginning Treatment _____ Fee: _____

☐ 150 Education Services Brief ☐

Client (Legal) Name:_____ **DOB**:_____/_____/_____ **SSN**: _____

Sex: ☐M ☐F **Race**: ☐white ☐black ☐hisp. ☐Other **Church Affiliation**:_____ **E-mail address:** _____

Address:_____
Street (Unit) City State Zip Code

County:_____ **Marital Status**:_____ **Household Income**: $_____ per ☐Yr ☐Mo.

Primary Phone:_____ ☐ Home ☐Work ☐Cell Check if we may: ☐ Call ☐Leave Voicemail ☐ Text

Secondary Phone:_____ ☐ Home ☐Work ☐Cell Check if we may: ☐ Call ☐ Leave Voicemail ☐ Text

Emergency Contact:_____ Phone:_____ Relationship:_____

☐ Check if you do not want to receive promotional material from Lutheran Social Services of Northwest Ohio.

☐ **I am financially responsible for myself and any charges I incur at Lutheran Social Services – if no, complete Responsible person info**

Responsible Person:_____ **Relationship**:_____

Address:_____
Street (Unit) City State Zip Code

Primary Phone:_____ ☐ Home ☐Work ☐Cell Check if we may: ☐ Call ☐Leave Voicemail ☐ Text

Secondary Phone:_____ ☐ Home ☐Work ☐Cell Check if we may: ☐ Call ☐ Leave Voicemail ☐ Text

☐ I **am financially responsible for the person listed above and any charges they incur at Lutheran Social Services**

If so: DOB:_____/_____/_____ **SSN**: _____

<u>Financially Responsible Party</u> (If not listed above). Please use Full Legal name as found on any insurance cards, etc.

Name:_____ **Relationship**:_____

Address:_____
Street (Unit) City State Zip Code

DOB:_____/_____/_____ **SSN**: _____

Primary Phone:_____ ☐ Home ☐Work ☐Cell Check if we may: ☐ Call ☐ Leave Voicemail ☐ Text

Secondary Phone:_____ ☐ Home ☐Work ☐Cell Check if we may: ☐ Call ☐ Leave Voicemail ☐ Text

<u>FINANCIAL INFORMATION</u>

☐ Medicaid ☐ Medicare ☐Private Insurance ☐EAP Involved ☐Self Pay/No Insurance

Insurance ID_____

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____
Signature of Client/Responsible Person Date

_____ _____
Signature of Witness Date

Rev 11/2020

Case # _____

LUTHERAN SOCIAL SERVICES OF NORTHWESTERN OHIO
FINANCIAL AGREEMENT

Client Name _____
(please print) **First** **MI** **Last**

Financial information is needed so that we may assist you in the best way possible. All information is kept confidential in accordance with federal and state laws. Please refer to our Notice of Privacy Practices and Client Confidentiality Statement which is posted in our front office and a copy provided to you.

Fees are based on a sliding fee scale. This scale takes into consideration the client's family income and number of dependents. ***Those who may benefit from fee reductions must:***

1. Verify family income. Our staff will assist you in determining what documentation you will need to provide for verification.
2. Allow the agency to bill and receive payment directly from any applicable insurance carrier. In the event that reimbursement from the third-party carrier and the amount collected from the client exceeds the cost for service, the agency agrees to reimburse the client any excess. If a client refuses to use a third-party resource available to him/her, the fee is set at the full cost of services provided (100% fee for service).

My financial responsibility is based on the information reported and I affirm that it is true to the best of my knowledge. Based on this information my fee has been set at $_____Diagnostic Assessment, $_____Individual, $_____NIOP Group, and $_____IOP Group. I understand that should my financial circumstances change, it is my responsibility to notify my service provider immediately. Income verification and fees may be reassessed annually.

I authorize Lutheran Social Services of Northwestern Ohio to furnish pertinent information to any entity that may be paying fully or in part for services received. I also understand that any payment that is denied will become my responsibility based on the current fee schedule. The service rates may be subject to change without advance notice.

If you have insurance, we will be glad to bill your insurance for you and assist you in getting the maximum benefits specified in your plan. However, it is important that you understand:

1. Not all Mental Health or Substance Abuse services are a covered benefit in all contracts. You will need to check with your employer or insurance company.
2. Your health benefit is a contract between you and your insurance company. Your exact benefits will be unknown to us until we receive the Explanation of Benefits (EOB) for your claim. Therefore, we are only able to approximate your insurance benefit. After payment is received from your insurance company, adjustments will be made by either refund or an additional bill to you.
3. Even though you may carry insurance, you, not the insurance company, are responsible for all fees for services you receive.
4. Our fees generally, but not necessarily, fall within the usual and customary rate structure determined by your carrier. You are responsible for fees outside the scale.
5. Co-pays and deductibles are due at the time service is provided. Deductibles renew on a yearly basis so you may be responsible for the full fee until you have met the deductible.
6. You are responsible to advise us of any change in insurance coverage immediately and allow us to copy your card on your next visit. If you fail to advise us of changes, you will be fully responsible for the fee of services rendered.

☐ **I do not wish to disclose financial information or have insurance filed and will pay full fee for services at 100%**

☐ **I have provided proof of income to qualify for a reduced fee**

☐ **ATTESTATION:**
I attest that my income at the present time is _____ ☐ wk ☐ mo ☐ yr. I cannot verify my

income because _____. I understand it is my duty to i

immediately report any changes in my financial circumstances to this agency. _____ ***client initials***

☐ **ZERO INCOME**:
I hereby declare that have no income at the present time. I am not currently drawing income from any source. I understand that it is my duty to immediately report any changes in financial circumstances to the agency**.** _____ ***client initials***

☐ Client given copy of agreement ☐ Client declined copy of agreement

I affirm that the above information is true and accurate to the best of my knowledge. I authorize direct payment of my third party benefits to Lutheran Social Services for services received.

Signature of Client or Legal Guardian Date

Signature of Agency Representative Date

Please list the members of your household:

Name	Relation	Age
	Self	

STAFF ONLY: **INCOME SOURCE / VERIFICATION**

☐ Employment	**$**	**>**	☐ 2 most recent pay stubs
☐ Self-employment	**$**	**>**	☐ Tax Returns
☐ Unemployment/Workers Comp	**$**	**>**	☐ Award Letter/Check Stub
☐ Alimony / Child Support	**$**	**>**	☐ Award Letter/Court papers/Check Stub
☐ SSI, SSDI, SS, OWF	**$**	**>**	☐ Award Letter/Court papers/Check Stub
☐ VA	**$**	**>**	☐ Award Letter/Court papers/Check Stub
☐ Medicaid/Ohio Disability	**$**	**>**	☐ Copy of Card Obtained
☐ Medicare/Insurance	**$**	**>**	☐ Copy of Card Obtained
Total Income (less documented child support)	**$**	**>**	**# of dependents including client*:**

Approved: 12.16.2020

LUTHERAN SOCIAL SERVICES OF NORTHWESTERN OHIO

DISCLOSURE / NOTICE OF ENROLLMENT in MACSIS

You and / or your dependents may be eligible for financial subsidy from your local Mental Health & Recovery Board. This subsidy may reduce the amount of financial obligation for the services received.

The Local Mental Health & Recovery Services Board may not be able to assist you with the payment for your services if this billing authorization statement or other necessary billing information is not completed.

To receive alcohol, drug addiction and / or mental health services paid for fully or in part by public funds, you must provide information to your county ADAMH Board. Lutheran Social Services will collect information at intake and submit billing information for services provided with your name and Social Security number to the Board for payment. Your local Mental Health & Recovery Services Board will:

- enroll you in the county behavioral healthcare plan,
- determine what public funds can be used to pay for all or part of your services, and
- pay service providers through the Multi-Agency Community Services Information System (MACSIS) connected with the Local Board of Recovery and Mental Health Services (Board ASM), the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, and Ohio Department of Jobs and Family Services.

All information will be kept confidential in accordance with applicable state and federal law. Name-identifying information will be used only to pay for services provided to you.

You are being asked to sign this Billing Authorization and Consent to Release that includes a disclosure statement for enrollment in MACSIS and a disclosure for billing statements. This allows the Mental Health & Recovery Services Board to use public funds to subsidize the cost of your services.

Lutheran Social Services may not be able to provide services after they begin billing through MACSIS if you do not agree to allow the Board to determine if you are eligible for public funds.

_____	_____
Client/Responsible Party	Date
_____	_____
Witness	Date

Rev 12.10

HEALTH HISTORY QUESTIONNAIRE

Client name: (First MI Last)	Age	Client Number

This form should be completed as fully as possible by client, but reviewed by medical or clinical staff. Clients should notify staff if they need assistance in completing this form.

**Do you have any Advanced Medical Directives such as a living will or medical power of attorney? Yes___ No___

If yes, what and who is contact?

Has the client had any of the following health problems?

	Now	Past	Never	Treatment Dates		Now	Past	Never	Treatment Dates
Anemia					Menstrual Pain				
Arthritis					Oral Health / Dental				
Asthma					Stomach / Bowel Problems				
Bleeding Disorder					Stroke				
Blood Pressure (high/low)					Thyroid				
Bone / Joint Problems					Tuberculosis				
Cancer					AIDS / HIV				
Cirrhosis / Liver Disease					Sexual Transmitted Disease				
Diabetes					Learning Problems				
Epilepsy / Seizures					Speech Problems				
Eye Disease / Blindness					Anxiety				
Fibromyalgia / Muscle Pain					Bipolar Disorder				
Glaucoma					Depression				
Headaches					Eating Disorder				
Head Injury / Brain tumor					Hyperactivity / ADD				
Hearing					Schizophrenia				
Heart Disease					Sexual Problems				
Hepatitis / Jaundice					Sleep Disorder				
Kidney Disease					Suicide Attempts / Thoughts				
Lung Disease					Other				

Please note family history of any of the above conditions and client's relationship to that family member.

[ ] NONE

Has the client had medical hospitializations / surgical procedures in the last 3 years? [ ] yes [ ] no If yes, complete informtion below.

Hospital	City	Date	Reason

How many doctor visits in the last 12 months? _____ Dentist? _____ Emergency Room? _____ Other Health Care? _____

Allergies / Drug Sensitivities [ ] None

Food (specify)

Medicine (specify)

Other (specify)

Pregnancy History [ ] not applicable

Currently pregnant? [ ] yes [ ] no If yes, expected delivery date.	Receiving prenatal care? [ ] yes [ ] no If yes, indicate provider.	Last menstrual cycle.
Any unusual or significant pregnancy. [ ] yes [ ] no If yes, explain.		Miscarriages [ ] NA

Nutritional Screening [ ] no problems

Eating: [ ] more [ ] less [ ] not eating	Appetite: [ ] increased [ ] decreased
Fluid intake: [ ] more [ ] less [ ] takes liquids only	Problems with? [ ] nausea [ ] vomiting [ ] chewing / swallowing

Special Diet / Other Concerns:

Pain Screening [ ] no problems

Does pain currently interfere with you life? [ ] yes [ ] no If yes, source of pain:

If yes, how much does it intrefere with activities: [ ] Not at all [ ] Mildly [ ] Moderately [ ] Severely [ ] Extremely

Has the client had any of the following symptoms in the past 60 days? Please check all that apply.

[ ] Ankle swelling	[ ] Coughing	[ ] Lightheadedness	[ ] Penile discharge	[ ] Urination difficulty
[ ] Bed-wetting	[ ] Cramps	[ ] Memory problems	[ ] Pulse irregularity	[ ] Vaginal discharge
[ ] Blood in stool	[ ] Diarrhea	[ ] Mole/Wart changes	[ ] Seizures	[ ] Vision changes
[ ] Breathing difficulty	[ ] Dizziness	[ ] Muscle weakness	[ ] Shakiness	[ ] Vomiting
[ ] Chest pain	[ ] Falling	[ ] Nervousness	[ ] Sleep problems	[ ] Other _____
[ ] Confusion	[ ] Gait unsteadines	[ ] Nosebleeds	[ ] Sweats (night)	_____
[ ] Consciousness loss	[ ] Hair change	[ ] Numbness	[ ] Tingling in arms & legs	_____
[ ] Constipation	[ ] Hearing loss	[ ] Panic attacks	[ ] Tremor	

Immunizations [ ] none [ ] unknown

[ ] Chicken pox	[ ] Diphtheria	[ ] German measles	[ ] Hepatitis B	[ ] Measles
[ ] Mumps	[ ] Polio	[ ] Small pox	[ ] Tetanus	[ ] Other:

Last Phys Exam by Prim Care Physician Date: Doctor: Phone: [ ] unk ( ) -

Height: **Weight:** Has weight changed in past year? If yes, + or - pounds

Substance Use History / Current Use (please check appropriate columns)

Caffiene [ ] if yes, ( ) coffee ( ) tea ( ) soda How much per week (cups, bottles)?

Tobacco [ ] if yes, ( ) cigarettes ( ) cigars ( ) chew How much per week (packs, etc.)?

	None	Past	Current		None	Past	Current		None	Past	Current
Sleep Medication	[ ]	[ ]	[ ]	Alcohol/Beer/Wine	[ ]	[ ]	[ ]	Inhalants	[ ]	[ ]	[ ]
Tranquilizers	[ ]	[ ]	[ ]	Marijuana	[ ]	[ ]	[ ]	Hallucinogens	[ ]	[ ]	[ ]
Pain Medication	[ ]	[ ]	[ ]	Cocaine/Crack	[ ]	[ ]	[ ]	Amphetamines	[ ]	[ ]	[ ]
Other:	[ ]	[ ]	[ ]	Stimulants	[ ]	[ ]	[ ]	Heroin	[ ]	[ ]	[ ]

Print name of person completing this form **Signature of person completing this form** **Date**

Clinician / Reviewer comments if any:

[ ] Review of medical history has taken place

Provider / Reviewer Signature / Credentials Date

Comments, Recommendations, or Referrals made by Reviewer [ ] No referral needed

Check referra(s) needed and specify action(s):

[ ] Primary care physician: _____

[ ] Healthcare agency: _____

[ ] Specialty care: _____

[ ] Other(specify): _____

Recommendations shared with client? If yes, client's response; if no, how will recommendations be shared with client?

[ ] yes [ ] no

Medical Reviewer Signature / Credentials (Nurse, PA, NP, MD, DO) if applicable Date

Lutheran Social Services
of Northwestern Ohio - Since 1911
A Christian Agency Serving People of All Ages

CONSENT FOR TREATMENT

Client Name: _____ **Case #** _____

LSS provides services to individuals and their families who have mental health or substance abuse / chemical dependency issues. The staff members are trained to provide appropriate treatment / services as based on guidelines and protocol for levels of care outlined by Ohio Department of Mental Health and Addiction Services.

[ ] I hereby consent to mental health treatment/services

[ ] I hereby consent to substance use disorder (SUD) treatment/services

LSS staff has also provided and reviewed with me (check all that apply):

___ Mission Statement and orientation to LSS services

___ Client Rights and Responsibilities

___ Grievance/Complaint Procedure

___ Client Confidentiality Handout

___ LSS Notice of Privacy Practices (HIPPA)

___ information on HIV/AIDS, TB and Hepatitis B and C (SUD Clients)

These documents are available for my future reference and are in effect through my treatment at LSS.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian (for minors) Date

_____ _____
Witness Signature Date

Approved: 01.20.2021

Lutheran Social Services
of Northwestern Ohio - Since 1911
A Christian Agency Serving People of All Ages

Client Name: _____ **Case #** _____

LSS provides services to individuals and their families who have mental health or substance abuse/chemical dependency problems. Staff members provide appropriate treatment/services based on guidelines from the Ohio Department of Mental Health and Addiction Services and the American Society of Addiction Medicine.

WHAT IS TELETHERAPY

Teletherapy is a behavioral health service provided via telephone or internet technology. Teletherapy is a real time, two way conversation using interactive technologies (audio, video or other electronic communications such as telephone, email, fax, and text) between a practitioner and client not in the same physical location. Both client and therapist need access to equipment and software: telephone or computer/smartphone/tablet with a webcam, videoconferencing software, and internet access with enough broadband for videoconferencing. Teletherapy has the same purpose and intention as in-person counseling. However, due to the nature of the technology used, teletherapy may be experienced somewhat differently than face-to-face, in-person treatment sessions.

HOW TELETHERAPY COMPARES TO TRADITIONAL IN PERSON CARE

Advances in communication technology have allowed teletherapy to evolve. This has been especially important for individuals living remotely in rural areas who do not otherwise have access to behavioral health services. The Canadian Agency for Drugs and Technology in Health reviewed 44 studies on telehealth services for acute or chronic mental health issues and determined that telehealth is as safe and effective as in-person care (2015). However, important verbal and non-verbal communication (such as body language, voice inflection) may not be as readily available. Therapy may therefore be less complete and progress may be slower. It is important that you are aware that teletherapy may or may not be as effective as in-person therapy; therefore your progress must be periodically evaluated for the effectiveness of this form of therapy. Teletherapy may not be for everyone and if you would be better served by an in-person provider or alternative service, you will be referred to a professional who can provide such services in your area. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this becomes the case in future, more appropriate services will be recommended.

CLIENT'S RIGHTS, RISKS, AND RESPONSIBILITIES FOR TELETHERAPY:

TECHNOLOGY REQUIREMENTS FOR TELETHERAPY

I understand that I am responsible for providing the necessary telephone or computer, telecommunications equipment, software and internet access with broadband capacity for my participation in teletherapy sessions. My therapist is responsible for providing the necessary telephone, or computer, telecommunication equipment, software, and internet access with broadband capacity to participate in teletherapy sessions.

RESTRICTIONS REGARDING CROSSING STATE LINES

I, the client, need to be a resident of Ohio. (This is a legal requirement for counselors and social workers practicing in this state under an Ohio license.) There are restrictions regarding crossing state lines for behavioral health services. Teletherapy provided by Lutheran Social Services NWO is under the jurisdiction of the state of Ohio, and is governed by the laws of that state. Therapists practicing under a license issued by the State of Ohio must only provide services to Ohio residents

ALTERNATIVE ASSESSMENT SERVICES AND FORMATS

I, the client, have the right to withhold or withdraw consent at any time for teletherapy 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. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face, in-person services. I also understand that if my counselor believes I would be better served by another form of therapeutic services (e.g. face-to-face service, in person) I will be referred to a professional who can provide such services in my area.

LIMITATIONS TO CONFIDENTIALITY INCLUDING MANDATORY REPORTING LAWS

The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my teletherapy is generally confidential. However, there are exceptions to

confidentiality including, but not limited to, reporting child, elder, or dependent adult abuse or neglect and expressed threats of violence towards self or others. Also, health records might be subpoenaed by a court for a legal proceeding.

HOW ASSESSMENT INFORMATION WILL BE RECORDED, STORED TRANSMITTED AND DISCARDED

I understand that all teletherapy records will be stored and retained as hard copy and as electronic documentation in the same confidential manner as in-person therapy.

THE RISKS OF TECHNOLOGY INCLUDE THE FOLLOWING

- The breach of confidential information including Private Health Information.
- The theft of my personal information
- The transmission of my information could be disrupted or distorted by technical failures.
- The transmission of my information could be interrupted or intercepted and accessed by unauthorized persons.
- I am responsible for information security on my computer.

SOFTWARE SECURITY PROTOCOL

I know that the technology used in teletherapy must include measures to safeguard data and to aid in protecting against intentional or unintentional corruption. Encryption of media offers some protection, but even with safe guards privacy and confidentiality of client information transmitted via any electronic channel cannot always be guaranteed.

ALTERNATIVE COMMUNICATION IF SESSION IS DISRUPTED BY TECHNOLOGY FAILURES

I understand that there is a risk that services could be disrupted or distorted by unforeseen technical problems. If online equipment fails and cannot be restored quickly the backup plan is to use a telephone to complete the session. If a telephone call is dropped or interrupted, the therapist will try to call the client again. Clients can call (419) 243-9178 for assistance.

RISKS AND BENEFITS PERTAINING TO RECEIVING THERAPY SERVICES

I understand that there are potential benefits and potential risks with participating in any psychotherapy. Benefits cannot be assured and my condition may not improve, and in some cases may even get worse.

EMERGENCY SERVICES

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I should call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in the future, my counselor will recommend more appropriate services.

PRIVACY AND SOME LIMITATIONS AND EXCEPTIONS

- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy.
- I am responsible for arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
- I will not include others in the session unless agreed upon with my therapist.
- Teletherapy sessions require proper attire.
- No recording of sessions is permitted and there is to be no sharing of session content on public forums such as Facebook or other social media.

I, _____, hereby consent to engage in teletherapy. Teletherapy is an interactive behavioral health service provided in real time via internet technology and/or telephone which can include assessment, treatment and the transfer of my medical data through audio, video, or other electronic communications. Teletherapy has the same purpose or intention as psychotherapy sessions conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than in person treatment sessions.

I have read, understand and agree to the information provided above regarding teletherapy and to my rights:

Client's Signature: _____ Date_____

Therapist's Signature: _____ Date_____

Parent or Guardian _____ Date_____

Revised 04.01.20

Lutheran Social Services
of Northwestern Ohio - Since 1911
A Christian Agency Serving People of All Ages

MISSION STATEMENT

In response to God's love for all persons, Lutheran Social Services of Northwestern Ohio provides human services that will strengthen the mental, moral, physical, social and spiritual well-being of those who seek this agency's services.

ABOUT LUTHERAN SOCIAL SERVICES OF NORTHWESTERN OHIO

Lutheran Social Services of Northwestern Ohio has been serving people in Northwestern Ohio and Southeastern Michigan for more than 100 years.

LSS is a private non-profit agency licensed by the Ohio Department of Mental Health and Addiction Services (OMHAS) and accredited by the Council on Accreditation (COA). Services of the agency are available without regard to religion, race, ethnicity, creed, sexual orientation, national origin, age, lifestyle, physical or mental impairment, or developmental disability

All services are confidential and are provided with maximum regard for privacy. Your written consent is required before any information about you can be shared outside the agency.

If you have any questions about the services you receive or about the agency's overall operation, please feel free to discuss them with your therapist.

Approved: 01.20.2021

FEE FOR SERVICE GUIDELINES

Lutheran Social Services establishes a self-pay fee for therapy based on one's ability to pay. If you have insurance, your insurance may cover a portion or all of the fee. If your insurance and self-pay fee together exceeds our hourly fee, your account will be adjusted accordingly.

INSURANCE GUIDELINES

If you have outpatient mental health coverage on your health insurance, your visits may be covered. Since medical insurance is a contract between you and your health carrier, responsibility for payment for services received rests with you. Responsibility for initiating precertification, if required, lies with you also. Failure to do so will result in your being responsible for the agency's full current fee.

Lutheran Social Services will bill your insurance carrier at our full rate for each clinical hour. Some insurance carriers will not pay us directly. Should you receive the reimbursement, you are responsible for forwarding the full amount to us, at which time your fee will be adjusted accordingly. Failure to forward the reimbursement to us will result in your being charged the agency's full current fee for those sessions.

SELF-PAY GUIDELINES

For Lutheran Social Services to provide professional therapy, ***you will be expected to pay your fee at time of service plus a portion of any past balance***. Failure to pay on your account may lead to termination of services. Since we are supported by the Lutheran churches and United Ways, your fee will be established on your income and family size. Our sliding scale for Mental Health and Substance Use services range from $40.00 to $149.88. Fees for educational services range from $18.50 to 102.31. If you have concerns about paying your fee, please discuss these with our Finance Department. Please notify your therapist 24 hours in advance if you cannot keep an appointment.

COLLECTION AGENCY

Lutheran Social Services will turn your account over to a collection agency if, after receiving notice, you fail to make payment arrangements. Future service may be denied if you have an outstanding bill.

QUESTIONS REGARDING YOUR BILL

If at any time you have questions regarding your bill or your insurance coverage, please do not hesitate to contact our Finance Department at 419-243-9178 or by fax 419-243-4450.

Approved: 01.20.2021

LUTHERAN SOCIAL SERVICES
of Northwestern Ohio – Since 1911

A Christian Agency Serving People of All Ages

NOTICE OF PRIVACY PRACTICES

Effective: January 20, 2021

THIS NOTICE DESCRIBES HOW CONFIDENTIAL 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:
Patty Hall, Lutheran Social Services, Privacy Officer, 2149 Collingwood Blvd., Toledo, Ohio, (419) 243-9178

WHO WILL FOLLOW THE REQUIREMENTS OF THIS NOTICE:

This notice describes our agency's practices and those of:

- Any health care professional authorized to enter information into your agency chart.
- All agency personnel, full-time, part-time, contractual or any interns and/or volunteer help.
- The Mental Health and Recovery Services Board of Lucas County and the Ohio Department of Mental Health and Addiction Services.

Confidentiality Requirements: As a certified agency of the Ohio Department of Mental Health and Addiction Services, confidentiality of client records are strictly protected. Agency staff shall not convey to a person outside of the agency that a client attends or receives services from the agency or disclose any information identifying a client as a mental health and/or an alcohol or other drug services client unless 1) the client consents in writing for the release of information, 2) the disclosure is allowed by a court order, 3) the disclosure is made to qualified personnel for a medical emergency, or 4) for audit or program evaluation purposes.

Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a client either at the agency or against any person who works for the agency; or any information about suspected elder and child abuse or neglect from being reported under state law to appropriate state or local authorities.

OUR PLEDGE REGARDING CLIENT INFORMATION:

We understand that information about you is personal and we are committed to protecting that information. We create a record of the care and services you receive at the agency and need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this agency.

We are required by law to:

- Assure information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose information.

- **For Treatment:** We may use information about you to provide you with services at our agency. We may disclose information about you to agency personnel who are involved in treating you. For example, a group facilitator.

- **For Payment:** We may use and disclose information about you so that the services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give the Mental Health and Recovery Services Board of Lucas County and/or the State Department of Mental Health and Addiction Services information about services you have received.

- **For Healthcare Operations:** We may use and disclose information about you for agency operations. These uses and disclosures may be necessary to run the agency and make sure that all of our clients receive quality care. For example, we may use information to review services and to evaluate the performance of the staff providing the services. We may also combine information about a number of agency clients to determine what additional services the agency should offer, what services are not needed, and whether certain treatments are effective.

.

- **Required By Law:** We will disclose information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**: We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat.

YOUR RIGHTS REGARDING INFORMATION ABOUT YOU

You have the following rights regarding information we have about you:

Right to Request Restrictions You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment or health care operations. To request restrictions, you must make your request in writing to the agency Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to insurance companies. We are not required to agree to your request.

Right to Request Confidential Communications You have the right to request that we communicate with you about matters involving your care at the agency in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Clinical Records Department. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right of Access to Inspect and Copy You have the right to inspect and copy information that may be used to make decisions about services provided to you. To do so, you must submit your request in writing to the agency Privacy Officer. If you request a copy of the information, we may charge a fee. We may deny your request to inspect and copy information if we determine, for example, that the information may present a danger to you or someone else. If you are denied access to information, you may request that the denial be reviewed. Another licensed health care professional chosen by the agency will review your request and the denial. We will comply with the outcome of the review.

Right to Amend If you feel that information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the agency. A request for an amendment must be made in writing and submitted to the agency Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
--Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
--Is not part of the information kept by or for the agency;
--Is not part of the information which you would be permitted to inspect and copy; or
--Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the agency Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You should receive a copy in the packet of information given to you at your initial visit. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the agency. The notice will contain on the first page in the top center, the effective date. In addition, each time you register at or are re-admitted to the agency for services, you will be offered a copy of the current notice in effect.

COMPLAINTS ***You will not be penalized for filing a complaint.***

If you believe your privacy rights have been violated, you may file a complaint with the agency or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Complaints to: Lutheran Social Services
Privacy Officer
2149 Collingwood Blvd.
Toledo, Ohio 43620

Complaints to: Office for Civil Rights
US Department of Health and Human Services
223 N Michigan Ave. Suite 240
Chicago, IL 60601

OTHER USES OF CLIENT INFORMATION

Other uses and disclosures of information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

LUTHERAN SOCIAL SERVICES
of Northwestern Ohio – Since 1911
A Christian Agency Serving People of All Ages

CLIENT GRIEVANCE/COMPLAINT PROCEDURES

It is the philosophy of this agency to encourage all clients to discuss their problems, concerns or complaints with their direct staff provider. However, should the need arise; clients have the right to file a grievance/complaint with the Client Rights Officer.

The Client Rights Officer of this agency is: Patty Hall, LSW 419-243-9178, phall@lssnwo.org

In addition, clients or persons filing a grievance/complaint on a client's behalf have the right to file a grievance/complaint with any of the organizations listed below at any time during the process.

Mental Health and Recovery Services Board
Of Lucas County Ohio
701 Adams St., Suite 800
Toledo, Ohio 43604
(419) 213-4600
(Contact information for additional boards available on request)

Ohio Department of Mental Health and Addiction Services
30 E Broad St, 11th Floor
Columbus, Ohio 43215
(614) 466-2596

Ohio Legal Rights Services
50 W Broad St, Suite 1400
Columbus, Ohio 43215-5923
1-800-282-9181

Midwest Regional Civil Rights Office
233 N. Michigan St, Suite 240
Chicago, IL 60601
(800) 368-1019

United States Dept of Health and Human Services
Office for Civil Rights
200 Independence Ave SW, Room 509 F, HHH Bldg
Washington, D.C. 20201

Ohio Department of Job and Family Services
30 E Broad St, 32nd Floor
Columbus, Ohio 43215
(614) 466-6650

Definition of Client Grievance: A written record of a client's allegation that one or more of his/her rights has been infringed upon. A grievance may be initiated by a client, a client's representative, or the Client Rights Officer.

When filing a grievance, the grievance must be filed with the Client Rights Officer within 30 days after the person filing the grievance became aware of the action alleged to be prohibited by the regulations. This time frame may be waived by the Client Rights Officer if extenuating circumstances exist which justify an extension.

All grievances must be written, dated and signed by the client or the person filing the grievance on behalf of the client and should include the date, approximate time, description of the incident and names and addresses of the individuals involved in the incident/situation being grieved. Clients will be given assistance in filing a grievance upon his/her request. Agency representation and investigation regarding the grievance will also be provided upon request. Grievances should be given to the Client Rights Officer of the agency. If the grievance involves the Client Rights Officer, the grievance can be given to the Vice President of the agency.

Discussion of the written grievance is first between the employee against whom the grievance has been made and the client. If there is no resolution, the client will contact the employee's immediate supervisor to discuss the grievance. If the grievance is not resolved, the Client Rights Officer will meet with the client. If the grievance is still not resolved, the Client Rights Officer will take the grievance to the Vice President. In the absence of the Vice President or if the grievance is against the Vice President, the Client Rights Officer will take the grievance to the Executive Director/CEO. If the grievance is resolved, a written report shall be given to the client.

The grievance process must be completed within 21 calendar days of receipt of the written grievance as follows: contact and discussion with the employee identified in the grievance within five (5) working days; contact and meeting with the immediate supervisor within three (3) working days; meeting with the Client Rights Officer within five working days; meeting with the Vice President or Executive Director/CEO within five (5) working days.

Within twenty-one (21) calendar days of receiving the grievance, the program will make a resolution/decision on the grievance. The process may include interviews with those involved in the incident, a review of client records, or a formal hearing with the Executive Director/CEO or designee; the Client Rights Officer will be available to assist the Grievant at any formal agency hearing. Any exceptions that cause this time period to be extended will be documented in the grievance file and written notification will be given to the client or persons filing a grievance on the client's behalf.

All grievances, associated documentation supplied by other interested parties, and evidence relative to the grievance will become part of the permanent grievance record to be kept on file for two years from the resolution.

The Client Rights Officer will assist the client in filing the grievance with the Client Rights Officer of the appropriate mental health and addictions services board as shown in the list at the top of the page, if requested. Should the grievance be against the Client Rights Officer, or if he/she is unavailable, the Vice President will appoint an alternate Client Rights Officer. A grievance may also be filed with one or more agencies listed above.

Definition of Client Complaint: A written record of a client's allegation that does not involve the violation of any client rights. A complaint may be initiated by a client, a client's representative, or the Client Rights Officer.

When filing a complaint, the complaint must be filed with the Client Rights Officer. The Client Rights Officer shall request that the CQI Committee review the client record in question and make any additional recommendations regarding the complaint to the Client Rights Officer. It is the responsibility of the Client Rights Officer to accept or reject the CQI Committee's recommendation and to respond accordingly.

Lutheran Social Services
of Northwestern Ohio - Since 1911
A Christian Agency Serving People of All Ages

CLIENT CONFIDENTIALITY

1. Confidentiality of client records is protected by Federal Law and Regulations. Lutheran Social Services will not convey to any person outside the program any information that identifies a client as an alcohol or other drug services' client or that a client is receiving or has received services at Lutheran Social Services unless:
    a. The client consents in writing for the release of information;
    b. The disclosure is allowed by a court order;
    c. The disclosure is made to qualified personnel for a medical emergency, continuity of care, research, audit, or program evaluation.
2. Violation of the Federal Law Regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations (see 42 U.S.C. 290 DD-3 and EE-3 for federal laws and 42 CFR Part 2 for federal regulations).
3. Federal Laws and Regulations *do not* protect any information about *suspected child or elder abuse or neglect* from being reported under state law to appropriate state or local authorities. This information will be reported.
4. Federal Law and Regulations *do not* protect any threat to commit a crime, any information about a crime committed by a client, *at any of the agency's facilities or against any person who works for said agencies.* Threats of this nature can legally be reported.
5. *Duty to Warn* rule requires that providers warn anyone whom they believe is in danger because of a credible threat made by a client. Authorities may also be notified to ensure protection to those threatened.

LUTHERAN SOCIAL SERVICES
of Northwestern Ohio – Since 1911

A Christian Agency Serving People of All Ages

CLIENT RIGHTS AND RESPONSIBILITIES

All staff involved with the operations of Lutheran Social Services of Northwestern Ohio (hereinafter referred to as the Agency) shall be familiar with Client Rights, which follow the State of Ohio Department of Mental Health and Addiction Services standards. There shall be documentation in each employee's personnel file, including part-time staff, volunteers and student interns, that he/she has received and reviewed copies of each. There shall also be documentation that he/she has agreed to abide by them. All clients and/or guardians are to receive a copy of this policy when they present for their first appointment; written documentation of receipt and understanding shall be maintained in the client Integrated Clinical Record (ICR). Persons receiving Community Services shall be advised that they can obtain a copy of the Client Rights and Responsibilities upon request.

Hours of service vary from location to location. A therapist is on call outside of hours of service and may be accessed by calling the agency answering service at 877-412-5293.

The agency has a policy of no restraint. The agency also has a policy of no harassment or violence against other clients or staff.

The person designated to coordinate compliance with Section 504 of the Rehabilitation Act of 1973 (Nondiscrimination against the Disabled) and who serves as the Client Rights Officer at the agency is: Patty Hall – 2149 Collingwood Blvd., Toledo, OH 43620, 419-243-9178.

CLIENT RIGHTS

Persons who receive mental health and/or alcohol and other drug treatment services within the agency have the following rights:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.
2. The right to receive services in a humane setting which is the least restrictive feasible as defined in the treatment plan.
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives.
4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client.
5. The right to receive services in a manner that is not coercive and protects the right to self-determination.
6. The right to a current, written, individualized service plan that addresses one's own mental, emotional and physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
7. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.
8. The right to freedom from unnecessary or excessive medication.
9. The right to freedom from unnecessary restraint or seclusion.
10. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan.
11. The right to be informed of and refuse any unusual or hazardous treatment procedures.
12. The right to be advised of and refuse observation by techniques such as one-way mirrors, recording devices, computers, television, movies, or photographs.
13. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.
14. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information, within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client in accordance with rule 5122:2-3-11 of the Administrative Code.
15. The right to access one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records.
16. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
17. The right to receive an explanation of the reasons for denial of service.
18. The right not to be discriminated against in the provision of services on the basis of religion, race, ethnicity, creed, sexual orientation, national origin, age, lifestyle, physical or mental impairment, or developmental disability.
19. The right to know the cost of services.
20. The right to be fully informed of all rights.
21. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service.
22. The right to file a grievance.
23. The right to have oral and written instructions for filing a grievance.
24. The right to be informed of available program services; and/or prevention services

In addition to the rights listed above, no person will be denied admission to a program due to their use of prescribed psychotropic medications.

CLIENT RESPONSIBILITIES

1. **BE SURE TO SAY SOMETHING TO YOUR THERAPIST IF THERE IS A PROBLEM, OR IF THE THERAPIST ISN'T GIVING YOU WHAT YOU WANT.**
   If something is uncomfortable, awkward or not the way you expected in therapy tell your therapist - discuss it before it creates problems in getting what you need from treatment.

2. **BE ON TIME FOR YOUR APPOINTMENTS AND KEEP TRACK OF WHEN YOUR APPOINTMENTS ARE SCHEDULED.**
   You must be responsible for your appointments. A pattern of missed appointments may result in discontinued service.

3. **TAKE AN ACTIVE ROLE IN DEVELOPING GOALS WITH THE THERAPIST, AS WELL AS THE ISSUES TO BE COVERED IN SESSIONS.**
   You and your therapist will work as a team and your input will be sought every step of the way.

4. **YOU GET OUT OF THERAPY WHAT YOU PUT INTO IT.**
   Success is directly related to your commitment and willingness to work hard. The more you put into it, the more you get out of it. Be sure to ask questions when something is unclear or you want to know something.

5. **AN IMPORTANT PART OF YOUR WEEK IS YOUR 50-MINUTE THERAPY SESSION. THERAPY IS AN IMPORTANT PART OF YOUR LIFE AND YOU NEED TO MAKE EVERY MINUTE COUNT. IT IS INTENDED TO BE ONE SOURCE OF ADDITIONAL SUPPORT, BUT NOT THE ONLY ONE. PUT INTO PRACTICE AT HOME WHAT YOU LEARN IN THERAPY.**
   50 minutes a week is not much time, so to maximize the benefits of therapy you will need to be working on it away from here - like homework. Tasks might include thinking or acting differently in certain situations or perhaps reading something, keeping a journal or going to a meeting (etc.). The more you work on this throughout the week, the more likely you will be to experience change and perhaps see it happen sooner.

6. **CHANGE DOESN'T JUST "HAPPEN", IT BEGINS WHEN YOU BEGIN TO DO THINGS DIFFERENTLY. THIS TAKES TIME.**
   Don't expect overnight miracles.

7. T**HINGS SOMETIMES GET WORSE BEFORE GETTING BETTER AS YOU LEARN ABOUT YOURSELF -- THAT'S OK.**
   You may experience a lot of different feelings because of the sensitive nature of what you are here about. You may discuss things that make you sad or angry. Don't assume that unpleasant feelings mean therapy is not helping. To the contrary, this is normal. There will be times that you feel good about tackling these concerns and making progress.

8. **WHEN PROGRESS IS MADE KEEP WORKING TOWARD YOUR GOALS. IT'S EASY TO SLIP BACK TO OLD PATTERNS.**
   The changes you will be making are lifelong so even when therapy ends you will need to work at maintaining the progress you have made.

9. **BE HONEST.**
   Most important! Otherwise you're wasting your time, our time and your money. Honesty is absolutely essential!

10. **YOUR SESSIONS ARE 50 MINUTES LONG. IF THERE IS A CRISIS OR SOMETHING YOU WANT TO TALK ABOUT, BRING IT UP BEFORE THE LAST FEW MINUTES OF YOUR SESSION.**

11. **WHEN CALLING YOUR THERAPIST, CALL ON A DAY YOU KNOW HE OR SHE WILL BE HERE. IF HE OR SHE IS NOT IN, PLEASE LEAVE A VOICE MAIL MESSAGE INCLUDING YOUR NAME, PHONE NUMBER, REASON FOR YOUR CALL, AND GOOD TIME FOR HIM OR HER TO RETURN YOUR CALL.**
    We do have an answering service after hours and on weekends to help you to be able to leave a message when necessary. 877-412-5293

12. **BE SURE TO PAY YOUR BILL IN ACCORDANCE WITH YOUR FEE AGREEMENT.**
    This will help prevent an interruption in services for you. A pattern of non-payment may result in discontinued services

13. **ATTEND YOUR SESSIONS FREE FROM THE INFLUENCE OF ALCOHOL OR OTHER DRUGS.**
    If you arrive for your session and we suspect you are under the influence of alcohol or other drugs, you will not be allowed to attend your session. If you drove yourself to the agency, you will need to make arrangements for someone to pick you up. If you drive away from the agency, police will be contacted in order to protect you and others. Repeatedly arriving under the influences may result in discontinued services.

CIVIL RIGHTS POLICY

It is the policy of the agency to treat all clients without regard to religion, race, ethnicity, creed, sexual orientation, national origin, age, lifestyle, physical or mental impairment, developmental disability, or due to having an HIV infection or AIDS. The same requirements are applied to all, and clients are assigned without regard to any of the above. There is no distinction in availability, eligibility for, the manner of providing client services, referring or recommending services with regard to religion, race, ethnicity, creed, sexual orientation, national origin, age, lifestyle, physical or mental impairment, developmental disability, or due to having an HIV infection or AIDS.

Any person who feels they have been discriminated against because of religion, race, ethnicity, creed, sexual orientation, national origin, age, lifestyle, physical or mental impairment, developmental disability, or due to having an HIV infection or AIDS has the right to file a grievance or complaint. Section 504 of the Rehabilitation Act prohibits discrimination based on disability. In accordance with the Section 504 Regulation, any program participant, participant representative, prospective participant or staff member who has reason to believe that she/he has been mistreated, denied services or discriminated against in any aspect of services or employment because of a disability may file a grievance. In order to implement this policy, this agency has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Health and Human Services regulation (45 CFR Part 84) implementing Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Section 504 states, in part, that “no otherwise qualified handicapped individual…shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…” The law and regulations may be examined in the office of the designated Officer listed above who has been designated to coordinate the efforts of the agency to comply with the regulations.

Revised: 12.5.2022

MENTAL HEALTH AND RECOVERY SERVICES BOARD OF LUCAS COUNTY
NOTICE OF PRIVACY PRACTICES

Effective Date: September 20, 2013

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:

Mental Health and Recovery Services Board of Lucas County's Privacy Officer or Client Rights Officer (419-213-4600)

OUR DUTIES

At the Mental Health and Recovery Services Board, we are committed to protecting your health information and safeguarding that information against unauthorized use or disclosure. This Notice will tell you how we may use and disclose your health information. It also describes your rights and the obligations we have regarding the use and disclosure of your health information.

We are required by law to: 1) maintain the privacy of your health information; 2) provide you Notice of our legal duties and privacy practices with respect to your health information; 3) abide by the terms of the Notice that is currently in effect; and 4) notify you if there is a breach of your unsecured health information.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

When you receive services paid for in full or part by the Board, we receive health information about you. We may receive, use or share that health information for such activities as payment for services provided to you, conducting our internal health care operations, communicating with your healthcare providers about your treatment and for other purposes permitted or required by law. The following are examples of the types of uses and disclosures of your personal information that we are permitted to make:

Payment - We may use or disclose information about the services provided to you and payment for those services for payment activities such as confirming your eligibility, obtaining payment for services, managing your claims, utilization review activities and processing of health care data.

Health Care Operations - We may use your health information to train staff, manage costs, conduct quality review activities, perform required business duties, and improve our services and business operations.

Treatment - We do not provide treatment, but we may share your personal health information with your health care providers to assist in coordinating your care.

Other Uses and Disclosures - We may also use or disclose your personal health information for the following reasons as permitted or required by applicable law: To alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; to reduce or prevent threats to public health and safety; for health oversight activities such as evaluations, investigations, audits, and inspections; to governmental agencies that monitor your services; for lawsuits and similar proceedings; for public health purposes such as to prevent the spread of a communicable disease; for certain approved research purposes; for law enforcement reasons if required by law or in regards to a crime or suspect; to correctional institutions in regards to inmates; to coroners, medical examiners and funeral directors (for decedents); as required by law; for organ and tissue donation; for specialized government functions such as military and veterans activities, national security and intelligence purposes, and protection of the President; for Workers' Compensation purposes; for the management and coordination of public benefits programs; to respond to requests from the U.S. Department of Health and Human Services; and for us to receive assistance from consultants that have signed an agreement requiring them to maintain the confidentiality of your personal information. Also, if you have a guardian or a power of attorney, we are permitted to provide information to your guardian or attorney in fact.

Uses and Disclosures That Require Your Permission
We are prohibited from selling your personal information, such as to a company that wants your information in order to contact you about their services, without your written permission.

We are prohibited from using or disclosing your personal information for marketing purposes, such as to promote our services, without your written permission.

All other uses and disclosures of your health information not described in this Notice will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the purposes stated in your written permission except for those that we have already made prior to your revocation of that permission.

Prohibited Uses and Disclosures
If we use or disclose your health information for underwriting purposes, we are prohibited from using and disclosing the genetic information in your health information for such purposes.

POTENTIAL IMPACT OF OTHER APPLICABLE LAWS

If any state or federal privacy laws require us to provide you with more privacy protections than those explained here, then we must also follow that law. For example, drug and alcohol treatment records generally receive greater protections under federal law.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights regarding your health information:

- Right to Request Restrictions**.** You have the right to request that we restrict the information we use or disclose about you for purposes of treatment, payment, health care operations and informing individuals involved in your care about your care or payment for that care. We will consider all requests for restrictions carefully but are not required to agree to any requested restrictions.*
- Right to Request Confidential Communications**.** You have the right to request that, when we need to communicate with you, we do so in a certain way or at a certain location. For example, you can request that we only contact you by mail or at a certain phone number.
- Right to Inspect and Copy. You have the right to request access to certain health information we have about you. Fees may apply to copied information.*
- Right to Amend. You have the right to request corrections or additions to certain health information we have about you. You must provide us with your reasons for requesting the change.*
- Right to An Accounting of Disclosures. You have the right to request an accounting of the disclosures we make of your health information, except for those made with your permission and those related to treatment, payment, our health care operations, and certain other purposes. Your request must include a timeframe for the accounting, which must be within the six years prior to your request. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Right to a Paper Copy of Notice. You have the right to receive a paper copy of this Notice. This Notice will also be made available at our website http://www.lcmhrsb.oh.gov/, but you may obtain a paper copy by contacting the Board Office.

To exercise any of the rights described in this paragraph, please contact the Board Privacy Officer at the following address or phone number:
419-213-4600 or 701 Adams Street, Suite 800, Toledo, OH 43604

***** *To exercise rights marked with a star (*), your request must be made in writing. Please contact us if you need assistance.*

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of our current Notice at our office and on our website at: http://www.lcmhrsb.oh.gov/. In addition, each time there is a change to our Notice, you will receive information about the revised Notice and how you can obtain a copy of it. The effective date of each Notice is listed on the first page in the top center.

TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the Board or with the Secretary of the Department of Health and Human Services. To file a complaint with the Board, contact the Privacy Officer at the address above. You will not be retaliated against for filing a complaint. If you wish to file a complaint with the Secretary, you may send the complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
Attn: Regional Manager
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

September 2013