



Welcome to the Boys Town Center for Behavioral Health!

Thank you for choosing us to assist you and your family. Please complete the attached forms and bring the completed forms with you to your first appointment. Please be sure to arrive at least 15 minutes early for your first appointment so that your paperwork can be reviewed and processed. Please do not attempt to e-mail or fax the completed forms to us – we must receive them in person.

If you have any questions or need assistance with completing any of the forms, please contact our staff at 531-355-3358. We look forward to serving you!

**Appt. Date:** \_\_\_\_\_

**Appt. Time:** \_\_\_\_\_

**Provider:** \_\_\_\_\_

## **OFFICE POLICY**

Welcome to the Boys Town Center for Behavioral Health! The information in this packet is provided to ensure that you have a full understanding of our office policies. Please read carefully, complete the enclosed documentation, and sign where indicated. This first sheet will be yours for future reference. If you need assistance with completing this form, please request assistance from one of our staff members or by contacting 531-355-3358. The information must be complete before you can be seen in our clinic.

Please arrive at least 15 minutes early for your first scheduled appointment to review your completed paperwork.

**FINANCIAL RESPONSIBILITY AND PAYMENT POLICY** – You are responsible for payment of all charges for mental health services provided, including any co-payments or deductibles. You are also required to provide an insurance card – this is necessary to validate coverage of benefits. You are ultimately responsible for any service provided that is not covered by your policy.

**INSURANCE** – You are responsible for any charges due to your insurance company. Your account with this office is your responsibility. As a courtesy to our clients, we will file insurance. It is your responsibility to notify us of any changes in your insurance plan. Any co-payments, deductibles, or services not covered by insurance are your financial responsibility. Any service denied because of a change in benefits becomes your responsibility.

**OFFICE HOURS** – Office hours are 8:00 a.m. to 6:00 p.m., Monday through Thursday, and 8:00 a.m. to 5:00 p.m. on Friday. To schedule appointments, please contact 531-335-3358.

**AFTER HOURS** – After clinic hours, phone calls will be answered by the Boys Town National Hotline. In the case of an emergency, call 911 or go to the nearest hospital emergency room.

**CANCELLATION** – Cancellations must be made at least 24 hours prior to your appointment; otherwise, a fee may be assessed. All routine phone calls, including rescheduling appointments and routine questions, will be handled during normal business hours.

**LATE APPOINTMENTS** – You may need to reschedule appointments if you are 15 minutes late.

**TERMINATION** – Termination of services may occur when three appointments are missed without proper cancellation or when treatment recommendations are not accepted or followed.

**FAMILY INVOLVEMENT** – The primary responsibility of each mental health provider is to provide the most effective treatment for each client. Involvement of the family is viewed as essential in maximizing treatment success.

**CLIENT RIGHTS** – Please review the client rights and responsibilities information posted in the reception area. A copy of this information is included in this packet.

**PRIVACY** – Please review Father Flanagan’s Boys’ Home Notice of Privacy, which describes how treatment information about you may be used and disclosed and how you can get access to your information. A copy of this practice is included in this packet.

## **PAYMENT POLICY**

Thank you for choosing us to assist you and your family. We are committed to providing you with the best care possible. As one of our clients, we want to ensure that you have a clear understanding of our payment policy. Please read this carefully and ask any questions that you may have.

1. **Insurance** – We participate in most insurance plans. You are responsible for any charges due to your insurance company. Your account with this office is your responsibility. As a courtesy to our clients, we will file insurance. Please present a copy of your insurance card at each visit. It is your responsibility to notify us of any changes in your insurance plan. Any service denied because of a change in benefits becomes your responsibility. Services not covered by your insurance are your financial responsibility.
2. **Co-payments, coinsurance, and deductibles** – All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. We are contractually obliged to collect the co-payment at the time of service. Coinsurance and deductible amounts may vary. A deposit of \$50 as a down payment that will be applied toward your coinsurance or deductible is expected at each visit until your coinsurance or deductible has been met. We accept cash, check, Visa, MasterCard, Discover, and American Express.
3. **Self-Pay** – Payment is expected at the time of service if we will not be submitting charges to insurance. A prompt pay discount may be offered. We accept cash, check, Visa, MasterCard, Discover, and American Express.
4. **Claim Submission** – We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
5. **Coverage changes** – If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits.

Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.

Our practice is committed to providing the best treatment to our clients. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

## BOYS TOWN CENTER FOR BEHAVIORAL HEALTH CLIENT INFORMATION SHEET

### Client Information

Last Name:		First:		MI:	Birth Date:	
Address:			City:		State:	Zip:
Home Phone:		Work Phone:		Marital Status:	Gender:	Is Client Currently a Student?
				M D S W	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:			Referring Physician:			
Person to Notify in Case of Emergency (friend or relative not living with you):						
Name		Relationship			Phone	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to Answer						
Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Not Hispanic or Latino Origin <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer						

### Responsible Party (Legal Guardian)

### Spouse/Other Parent

Last Name:		First:	M.I.:	Birth Date:	Last Name:		First:	M.I.:	Birth Date:		
Address:				Address:							
City:		State:	Zip:	City:		State:	Zip:				
Home Phone:		Work Phone:	Cell Phone:	Home Phone:		Work Phone:	Cell Phone:				
E-mail Address:			Relationship to Client:		E-mail Address:			Relationship to Client:			
Circle One:		Employed	Unemployed	Disabled	Retired	Circle One:		Employed	Unemployed	Disabled	Retired
Employer Name:				Employer Name:							
Employer Address:				Phone:		Employer Address:				Phone:	

### Primary Insurance Information

### Secondary Insurance Information

Insurance Co. Name:				Insurance Co. Name:			
Insured's Name:				Insured's Name:			
Relationship to Client:				Relationship to Client:			
Policy #:		Group #:		Policy #:		Group #:	
Effective Date:		Insurance Phone #:		Effective Date:		Insurance Phone #:	

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that the benefit information that our office staff obtained is a courtesy and is NOT a guarantee that insurance will pay for the services provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that the Clinic will bill you for any outstanding amounts owed. **You are responsible for reporting any insurance changes to the front desk staff at the time of your appointment.**

\_\_\_\_\_  
NAME OF RESPONSIBLE PARTY

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

# BOYS TOWN CENTER FOR BEHAVIORAL HEALTH – AGREEMENT AND CONSENT TO TREAT

Please read and review the following pages for an explanation of our office policies and keep them for your reference.

**Please Initial:**

### FINANCIAL RESPONSIBILITY AND PAYMENT POLICY

\_\_\_\_\_ I agree that I am responsible for payment of all charges for mental health services provided to me, including any copayments or deductibles. I understand that I am responsible for notification at the time of the visit of any benefit changes in my insurance plan. I further understand that I am responsible for any service provided to me that is not covered by my policy. I accept financial responsibility for the services provided to me by the Boys Town Center for Behavioral Health (the Clinic).

### NOTICE OF PRIVACY AND CLIENT RIGHTS

\_\_\_\_\_ I have received the Boys Town Notice of Privacy, which describes how confidential health information about the client may be used or disclosed and how to get access to this information. I have also received a copy of the Boys Town Center for Behavioral Health Client Rights & Responsibilities. (For Magellan clients, a copy of the Magellan Member Rights & Responsibilities has been received.)

### CONSENT TO TREATMENT

\_\_\_\_\_ The Boys Town Center for Behavioral Health works with children and their families to identify and treat such issues as depression, anxiety, school problems, and ADHD. The Clinic offers specialized services, including behavioral and psychological assessments as well as counseling. I, knowing that the client has a condition requiring diagnosis and treatment, do hereby voluntarily consent to such treatment by the Boys Town Center for Behavioral Health staff, assistants, or designees as is, in their judgment, necessary. I further acknowledge that no guarantees have been made to me as to the results of treatment. I authorize you to provide reasonable and proper care by today's standards. If applicable, I have informed my treating provider of my mental health advance directives and have provided a copy for mental health decision-making that will become part of my treatment record.

### CONTACT BY TELEPHONE

\_\_\_\_\_ I understand that by providing my landline or mobile number(s), I give my consent for the Clinic, their agents, and their collection agents to contact me at these numbers, or at any number that is later acquired for me, and to leave live or pre-recorded messages, or voice or text messages, regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer. Providing a telephone (landline or mobile) number is not a condition of receiving services.

You may contact me by text:	Yes _____ No _____	Phone number: _____
You may contact me by phone:	Yes _____ No _____	
You may leave a message on my phone:	Yes _____ No _____	

\_\_\_\_\_ I understand that appointments may be videotaped for supervision purposes. This is to ensure that your family receives the highest quality of care. Your therapist will request a separate consent form be completed if he/she would like to use the videotaped appointment for any reason other than supervision.

### PERMISSION TO FURNISH INFORMATION FROM RECORDS

**(Please Initial one)**

\_\_\_\_\_ - **YES** I understand that certain medical information regarding the client may need to be released by the Clinic to third-party payers in order to obtain payment for the services provided. I hereby authorize and request the Boys Town Center for Behavioral Health staff to furnish medical information requested by the health insurance carrier or any other third-party payer. I authorize contact with my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy, and I authorize my insurance company or health plan administrator to release information to the Boys Town Center for Behavioral Health.

\_\_\_\_\_ - **NO** I understand that even though I may have insurance that covers these services, I have selected to be financially responsible rather than submit to my insurance carrier.

### COORDINATION OF CARE

\_\_\_\_\_ I understand that in order to provide the highest level of care, the Clinic may request permission to discuss relevant aspects of care with other providers serving the client. Such providers may include but are not limited to: physicians, school personnel, and previous mental health providers. When contact with other providers is requested, a separate Authorization for the Release of Information will be completed and signed for each provider. If your clinician may communicate with the client's primary care provider (physician) about today's appointment, please sign the attached Authorization for the Release of Information Primary Care Provider form and return it with this form.

### PLAYROOM AND TEEN ROOM

The Playroom and Teen Room are provided for convenience only and are monitored by a live video feed. Children and their parents/guardians shall use the Playroom or Teen Room at their own risk. Father Flanagan's Boys' Home shall assume no liability or responsibility for any damage, loss, injury or any liability of any kind resulting from anyone's use of the Playroom or Teen Room.

### NEBRASKA HEALTH INFORMATION INITIATIVE (NeHII)

Boys Town is a participating provider in the Nebraska Electronic Health Information Exchange (NeHII), a state-wide, internet-based, health information exchange. Your client demographic information will automatically be included in NeHII unless you opt-out now or if you previously opted-out. In order to opt-out of this program, you must dial 866-978-1799 or visit [www.connectnebraska.net](http://www.connectnebraska.net).

### STATEMENT OF UNDERSTANDING

Signing below indicates that I have read or have had read to me the contents of this document and have received pertinent information regarding Office Policies, Client Rights & Responsibilities, and Notice of Privacy. I agree to abide by the stated terms and conditions of service provision. I agree that these provisions will remain in effect until I provide written revocation to the Clinic. If I am signing for someone other than myself, I represent that I have legal authority to do so.

\_\_\_\_\_  
Print Client Name  
(If a minor, person authorized to sign for Client)

\_\_\_\_\_  
Signature of Client  
(If a minor, person authorized to sign for Client)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date



**FATHER FLANAGAN'S BOYS' HOME**

**NOTICE OF PRIVACY PRACTICES**

**EFFECTIVE DATE: December 1, 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.

**OUR PLEDGE REGARDING YOUR INFORMATION:**

At Father Flanagan's Boys' Home we are committed to protecting the personal information we obtain about you while providing services through our continuum of child and family services. We are required by law to follow the privacy practices described in this Notice. We may change our privacy practices at any time. Such revised privacy practices will be set forth in a revised Notice and will be effective for all service information that we maintain at that time. A current copy of our Notice of Privacy Practices will be posted in a visible location at all times in our Youth Care Building, 13603 Flanagan Boulevard, in our National Headquarters Building at 14100 Crawford St. both at Boys Town, NE 68010, and at the headquarters offices of each of Father Flanagan's Boys' Home affiliate corporations. In addition to the places already identified, this Notice will also be posted on the following website: [www.boystown.org](http://www.boystown.org).

**WHO WILL FOLLOW THIS NOTICE:** This notice describes the privacy practices of Father Flanagan's Boys' Home, its operating divisions, its affiliate corporations, and their respective health care and youth care professionals, their business associates, and any other person or entity obligated by contract or applicable law to adhere to such privacy policies (hereinafter collectively referred

to as "Boys Town"). Each of the foregoing individuals and entities may use, share, and/or disclose medical, service, and other personal information with each other for the treatment, payment, or health care operations purposes described herein.

**UNDERSTANDING YOUR RECORD /INFORMATION:**

When you begin services with Boys Town, a record is created. This record may include personal information about you, your physical, mental and behavioral health, treatment and diagnosis, and other information related to services rendered by Boys Town (such information is collectively referred to herein as "Your Information"). Your Information may be in the form of a medical record, a client record, a combination of these or another type of written service record. Your Information may be protected by certain state and federal laws and regulations. For instance, The Health Insurance Portability and Accountability Act (HIPAA), regulates Boys Town's use of protected health information. "Protected health information" is Your Information, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services and is maintained by a covered entity or the business associate of a covered entity. Boys Town uses Your Information to plan your care, to provide treatment to you, and to provide other medical and non-medical services to you. Your Information is also used as a communication tool by the many providers at Boys Town and by insurance companies (when applicable) to verify that services we billed for were actually provided. Although owned by Boys Town, you do have certain rights with regard to Your Information. This notice will tell you about the ways in which we may use and disclose Your Information to others. It also describes your rights and certain obligations we have regarding the use and disclosure of Your Information.

**BOYS TOWN'S DUTIES:** Boys Town is required by law to maintain the privacy of your protected health information, to provide you this notice of Boys Town's legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. Boys Town is also required to abide by the terms of this Notice currently in effect.

**HOW WE MAY USE AND DISCLOSE SERVICE INFORMATION ABOUT YOU:**

The following categories describe different ways we use and disclose Your Information without your authorization. For each category of uses and disclosures, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. Many of the ways we are permitted to use and disclose information will fall within one of the identified categories.

**•For Treatment:** Your Information obtained by Boys Town will be recorded in your client record and used to determine the course of your treatment and other services. We will use or disclose Your Information to provide, coordinate, and manage your health and youth care and related services. For example, Boys Town team members will communicate with one another personally and through your service record to coordinate your care. We may disclose Your Information to another entity, such as a legal guardian or placing agency, or another youth care provider or health care provider who becomes involved in your care.

**•For Payment:** We may use and disclose Your Information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may tell your health plan about a treatment you are going to receive to obtain approval or to determine whether your health plan will cover the treatment. We may also

- disclose Your Information to another service provider for its payment purposes.
- **For Health Care Operations:** We may use and disclose Your Information for Boys Town’s health care operations. These uses and disclosures are necessary to operate the entity and promote quality care. We may combine information about many service recipients to decide what additional services we should offer, what services are not needed, and whether certain new treatments and services are effective. We may disclose Your Information to doctors, nurses, technicians, medical students and other personnel. We may also disclose Your Information to entities outside of Boys Town for certain health care operations of the other entity so long as both entities have a relationship with you. We may also combine Your Information with information from other health care providers to compare how we are doing and see where we can make improvements in care and services. We use best efforts to remove information that identifies you from this set of information.
  - **For Youth Care Operations:** We may use and disclose, as needed, Your Information in order to support the business activities of Boys Town. These activities include, but are not limited to, quality assessment and improvement activities, employee review activities, training of students (interns), licensing, marketing, and fundraising, and conducting or arranging for other business activities. We may disclose Your Information to entities outside of Boys Town for certain youth care operations of the other entity so long as both entities have a relationship with you. We may also combine Your Information with information from other youth care providers to compare how we are doing and see where we can make improvements in care and services. We may remove information that identifies you from this set of information so that others may use it to study youth care and youth care delivery without learning service recipient specifics.
  - **Fundraising Activities:** We may use Your Information as part of a fundraising effort. We may also disclose Your Information to our related foundations, which may in turn contact you in raising money for Boys Town operations. Typically we will only release demographic information, such as your name, address and phone number, the dates you received services. However, no protected health information will be used for fundraising activities without your prior written consent. If you do not want to be contacted for any fundraising efforts, you must notify in writing either the Chief Compliance Officer for Youth Care or the Boys Town National Research Hospital Privacy Officer, depending on which division is conducting the fundraising efforts.
  - **Notification/Communication of Your Condition:** We may use or disclose Your Information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We will only release this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf. Unless state or federal law otherwise restricts us, or unless you instruct us not to, we may release your location within Boys Town’s facilities and general condition to people who ask for you by name. In addition, we may release your name, location, general condition and religious affiliation to members of the clergy.
  - **Research:** We may disclose Your Information to researchers employed by us or other business associates when their research has been approved by a privacy board or an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of Your Information. In addition, we may disclose your non-protected health information to researchers in preparation of research.
  - **As Required by Law:** We may use or disclose Your Information when required to do so by federal, state or local law.
  - **Organ and Tissue Donation:** Consistent with applicable law, we may disclose Your Information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
  - **Workers’ Compensation:** We may release Your Information for workers’ compensation or similar programs that provide benefits for work-related injuries or illness.
  - **Public Health Activities:** We may disclose your service information to a public health authority that is permitted by law to collect or receive the information. This includes reporting child abuse, domestic violence or neglect, FDA regulated products or activities, and exposure to communicable diseases. We may be required to report information to help prevent or control disease, injury, or disability. We may also disclose information, if directed by the public health authority, to a foreign government agency that collaborates with the public health authority.
  - **Military Activity and National Security:** We may use or disclose the service information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your service information to authorized federal officials for conducting national security and intelligence activities, including providing protective services to the President of the United States or others.
  - **Law Enforcement:** Under certain circumstances, we may disclose Your Information to law enforcement officials, with some examples being:

- reporting actual or threatened mental harm or physical injuries;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- inquires as to the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- to alert authorities of a death we believe may be the result of criminal conduct;
- information we believe is evidence of criminal conduct occurring on our premises;
- if we believe in good faith that a disclosure of your service information is necessary to prevent or minimize a serious threat to you or the public's health or safety;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; and
- we may release Your Information to correctional institutions or law enforcement officials if you are an inmate of a correctional institution or under the custody of a law enforcement official.
- **Coroners, Medical Examiners and Funeral Directors:** We may provide Your Information to a coroner or medical examiner. For example, such disclosure may be necessary to identify a person who has died or to determine the cause of death. We may also provide Your Information to funeral directors who need to carry out their duties.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may be required to disclose service information about you in response to a court or administrative order. We may also be required to disclose service information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to tell you about the request or to obtain an order protecting the information requested.

• **Public Health and Health Oversight**

**Agencies:** We may disclose Your Information to health oversight agencies, public health authorities, or other government agencies that monitor the health care system, related government programs, and compliance with applicable civil rights laws.

**Health Information Exchange:** We may participate in one or more electronic health information exchanges which permit us to exchange Your Information with other participating providers, health plans, and their business associates. For example, we may permit a health plan that insures you to electronically access Your Information to verify a claim for payment of services rendered by us. Or, we may permit a physician providing care to you to electronically access Your Information in order to have up to date information with which to treat you. Participation in a health information exchange also lets us access medical information electronically from other participating providers and health plans for our treatment, payment, and youth- and health-care care operations purposes as described in this Notice. We may in the future allow other parties, for example, public health departments that participate in the health information exchange, to access Your Information electronically for their permitted purposes.

**OTHER USES AND DISCLOSURES:** Other uses and disclosures of Your Information not covered by this notice or the laws that apply to us may require your specific written authorization. If you provide us authorization to use or disclose Your Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose Your Information for the reasons covered by your written authorization, except where permitted by law. You understand that we are unable to take back any uses or disclosures we have already made in reliance on your authorization and that we are required to retain records of care provided.

**YOUR RIGHTS REGARDING YOUR INFORMATION:** You have the following rights regarding Your Information:

- **Right to Notification in the Case of Breach:** We are required by law to notify you of a breach of your unsecured protected health information. We will provide such notification to you without unreasonable delay, but in no case later than 60 days after we discover the breach.
- **Right to Inspect and Copy:** You have the right to inspect and copy Your Information that may be used to make decisions about your care. Usually this includes service and billing records. This does not include psychotherapy records. You must submit your request to inspect and copy Your Information in writing to either the Chief Compliance Officer for Youth Care or the Boys Town National Research Hospital Medical Records Director, depending on which division provided services. Our office may charge you a reasonable fee for copying, mailing, labor and supplies associated with your request. If we maintain Your Information electronically in one or more designated record sets and if you ask for an electronic copy, we will provide the information to you in the form and format you request, if it is readily producible. If we cannot readily produce the record in the form and format you request, we will produce it in another readable electronic form we both agree to. In addition to the costs described above, we may charge a cost-based fee for our staff to make the electronic copy. If you direct us to transmit Your Information to another person, we will do so, provided your signed, written direction clearly designates the recipient and location for delivery. All requests are subject to reasonable notice and reasonable time to produce the requested information. In addition, we may deny your request to inspect and copy Your Information in certain circumstances. If you are denied access to Your Information, you may request that the denial be reviewed. We will provide you, in writing, with our



reasons for the denial of access and with instructions for having a denial of access reviewed.

• **Right to Amend:** You may request an amendment of Your Information that we maintain. Such a request must be in writing and provided to our BTNRH Privacy Officer.

A request for an amendment of medical information must be in writing and provided to the BTNRH Medical Records Director. In addition, you must provide a reason that supports your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement that will become part of your service information. If you file a statement of disagreement, we reserve the right to respond to your statement. You will receive a copy of any response we make and any such response will become part of your service information.

• **Right to an Accounting of Disclosures:**

You have the right to request an accounting of disclosures, which is a list of certain disclosures of Your Information. Your right to an accounting does not include disclosures for treatment, payment and youth and healthcare operations and certain other types of disclosures, for example, as part of a facility directory or disclosures made with your written authorization. To request an accounting of disclosures, you must submit a request in writing to the Privacy Officer. To request an accounting of medical disclosures, you must submit a request in writing to the BTNRH Medical Records Director. Your request must state a time period that is not 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 of disclosures you request within a 12-month period will be free. We may charge for the costs of providing additional lists. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

• **Right to Request Restrictions:** You have the right to request a restriction or limitation on Your Information that we may use or disclose for treatment, payment or youth or healthcare operations. You also have the right to request a limit on Your Information we disclose to someone who is involved in your care or the payment for care, like a family member or friend. Except as described below, we are not required to agree to your request. If we do agree to the requested restriction, we may not use or disclose Your Information in violation of that restriction unless there is an emergency. We are required to agree to your request that we not disclose certain protected health information to your health plan for payment or health care operations purposes, if you pay out-of-pocket in full for all expenses related to that service prior to your request, and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of Your Information to your health plan, we will assume you have withdrawn your request for restriction. To request restrictions, you must make your request to the Chief Compliance Officer for Youth Care or the BTNRH Privacy Officer depending on which division provided services. 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.

• **Right to Request Confidential**

**Communications:** You have the right to request that we communicate with you about Your Information in a certain way or at a certain location. Your request must be in writing, addressed to our Privacy Officer and must specify how or where you wish to be contacted. We will not ask you for the reason for your

request. We will accommodate reasonable requests.

• **Right to a Paper Copy of this Notice:** You have the right to request a paper copy of this Notice. To obtain a paper copy of this Notice, contact the Chief Compliance Officer for Youth Care. You may obtain an electronic copy of this notice at [www.boystown.org](http://www.boystown.org).

• **Our Responses to Your Requests:** We will respond to your requests to exercise any of the above rights on a timely basis in accordance with our policies and as required by law.

**CHANGES TO THIS NOTICE:** We reserve the right to or may be required by law to change our privacy practices, which may result in changes to this Notice. We further reserve the right to make the revised or changed Notice effective for service information we already have about you as well as any information we receive in the future. The Notice will contain the version number and effective date.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the Chief Compliance Officer of Youth Care or with the Secretary of the Department of Health and Human Services. ***You will not be penalized or otherwise retaliated against for filing a complaint.***

**CONTACT:** If you have any questions or would like additional information about this notice or our Privacy Practices, please contact our Chief Compliance Officer for Youth Care at the address set forth below:

Boys Town  
Attention: Chief Compliance Officer  
for Youth Care  
13603 Flanagan Boulevard  
Boys Town, NE 68010  
Phone: 402-498-1935  
Facsimile: 402-498-3378  
E-mail:

ChiefComplianceOfficerYouthCare@boystown.org

# Behavioral Health Clinic Client Rights & Responsibilities

## **CLIENT RIGHTS TO SERVICES**

### **You have a right to:**

- reasonable access to services regardless of race, religion, gender, sexual orientation, or ethnicity.
- be informed about the qualifications of the Clinical staff who are responsible for the client's care, treatment, and services.
- receive services in the Clinic during Clinic business hours.
- receive individualized treatment.
- refuse care, treatment, and services and to be informed about what will happen if this occurs.

## **RESPONSIBILITIES OF CLIENTS**

### **It is your responsibility to:**

- provide the Clinic with your current contact information and to notify the Clinic staff of any changes.
- keep scheduled appointments and, when necessary, cancel them at least 24 hours in advance.
- participate in an informed way in the decision-making and treatment planning process and have family members participate in such planning.
- follow treatment recommendations.

## **COMPLAINTS OR GRIEVANCES**

### **If you have a complaint or grievance:**

- you have the right to file a complaint or grievance without interference or retaliation.
- about the quality of services, you have the right to contact the Department Director, or you can call the Boys Town Hotline at **1-800-218-8032** (24 hours a day/7 days a week).
- you also have the right to file a grievance with:
  - Health and Human Services
  - Council on Accreditation



Authorization to Release/Request Confidential Information To Primary Care Provider

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
[ ] Released and/or [ ] Requested

- [ ] I do authorize Boys Town to contact/communicate with my child's / my Primary Care Provider.
[ ] I do NOT authorize Boys Town to contact/communicate with my child's / my Primary Care Provider.

To/From (of Primary Care Provider/Clinic)

Name: \_\_\_\_\_
Clinic: \_\_\_\_\_
Address: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
email address is only required if this is the means of disclosure
Email address: \_\_\_\_\_

Release Format: [ ] Paper [ ] Electronic

Release Method: (check all that apply): [ ] Email [ ] Mail [ ] Fax [ ] Pick up [ ] Verbal [ ] Other: \_\_\_\_\_

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing to Boys Town Records, at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.
Unless revoked, this authorization will expire in one (1) year from the date signed or on the following date/event whichever occurs sooner. Date \_\_\_\_\_ or Event \_\_\_\_\_
Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
Any disclosure of information has the potential for re-disclosure, and may not be protected by federal confidentiality rules.
Requests for copies of records may be subject to fees in accordance with applicable law.
If I request release by unencrypted email or another unsecure method, I have been warned of and accept the security risks to the information associated with the unsecure transmission, and Boys Town is not responsible for breach notification or liable for disclosures that occur in transit.

Print Client Name
(if a minor, person authorized to sign for Client)

Signature of Client
(if a minor, person authorized to sign for Client)

Relationship to Client

Date

Boys Town Records: 13460 Walsh Drive
Boys Town, NE 68010

Phone Number: 531-355-3358
Fax Number: 531-355-3375

**Risk of using email**

Transmitting client information by email has a number of risks that the client or legal guardian (email recipient) should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous pages and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after the sender of the recipients has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.
- Email on shared email accounts can be viewed by more than the intended recipient.

**Conditions for the use of email**

Boys Town Behavioral Health will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, Boys Town Behavioral Health cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by Boys Town Behavioral Health's intentional misconduct. Thus, email recipients must consent to the use of email for treatment information. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the email recipients concerning diagnosis or treatment will be printed out and made part of the client's records, and other individuals authorized to access the client records, such as staff and billing personnel, will have access to those emails.
- Boys Town Behavioral Health may forward emails internally to its staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling and/or as otherwise permitted by contract or applicable law. Boys Town Behavioral Health will not, however, forward emails to independent third parties without the client's/legal guardian's prior written consent, except as authorized or required by law.
- Although Boys Town Behavioral Health will endeavor to read and respond promptly to an email from an email recipient, Boys Town Behavioral Health cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, an email recipient shall not use email for medical emergencies or other time-sensitive matters.
- If an email recipient's email requires or invites a response from Boys Town Behavioral Health, and the email recipient has not received a response within a reasonable time period, it is the email recipient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The email recipient is responsible for informing Boys Town Behavioral Health of any types of information he/she does not want to be sent by email.
- The email recipient is responsible for protecting his/her own password or other means of access to email. Boys Town Behavioral Health is not liable for breaches of confidentiality caused by the client, his/her parent(s) or legal guardian(s), or any third party.
- It is the email recipient's responsibility to follow up and/or schedule an appointment if warranted.

**Guidelines for email communication**

To communicate by email, the email recipient shall:

- Inform Boys Town Behavioral Health of changes to his/her email address.
- Put the client's name and date of birth in the body of the email, not in the subject line.
- Withdraw consent only by written communication.
- Include the category of the communication in the email's subject line, for routing purposes (e.g., billing question).
- Review the email to make sure it is clear and that only relevant information is provided before sending to Boys Town Behavioral Health.
- Limit disclosure of treatment and sensitive information regarding client in the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding his/her computer password.



## Behavioral Health Clinic E-mail Information Form

### Risk of using e-mail

Transmitting client information by e-mail has a number of risks that the client or legal guardian (e-mail recipient) should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous pages and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender of the recipients has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.
- E-mail on shared e-mail accounts can be viewed by more than the intended recipient.

### Conditions for the use of e-mail

Boys Town Behavioral Health will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Boys Town Behavioral Health cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Boys Town Behavioral Health's intentional misconduct. Thus, e-mail recipients must consent to the use of e-mail for treatment information. Consent to the use of e-mail includes agreement with the following conditions:

- All e-mails to or from the e-mail recipients concerning diagnosis or treatment will be printed out and made part of the client's records, and other individuals authorized to access the client records, such as staff and billing personnel, will have access to those e-mails.
- Boys Town Behavioral Health may forward e-mails internally to its staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling and/or as otherwise permitted by contract or applicable law. Boys Town Behavioral Health will not, however, forward e-mails to independent third parties without the client's/legal guardian's prior written consent, except as authorized or required by law.
- Although Boys Town Behavioral Health will endeavor to read and respond promptly to an e-mail from an e-mail recipient, Boys Town Behavioral Health cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, an e-mail recipient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If an e-mail recipient's e-mail requires or invites a response from Boys Town Behavioral Health, and the e-mail recipient has not received a response within a reasonable time period, it is the e-mail recipient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The e-mail recipient is responsible for informing Boys Town Behavioral Health of any types of information he/she does not want to be sent by e-mail.
- The e-mail recipient is responsible for protecting his/her own password or other means of access to e-mail. Boys Town Behavioral Health is not liable for breaches of confidentiality caused by the client, his/her parent(s) or legal guardian(s), or any third party.
- It is the e-mail recipient's responsibility to follow up and/or schedule an appointment if warranted.

### 3. Guidelines for e-mail communication

To communicate by e-mail, the e-mail recipient shall:

- Inform Boys Town Behavioral Health of changes to his/her e-mail address.
- Put the client's name and date of birth in the body of the e-mail, not in the subject line.
- Withdraw consent only by written communication to Boys Town Behavioral Health.



## Behavioral Health Clinic E-mail Information Form

- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that only relevant information is provided before sending to Boys Town Behavioral Health.
- Limit disclosure of treatment and sensitive information regarding client in the e-mail.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.

### Acknowledgment and Agreement

I, whether for myself or on behalf of the below-identified client, acknowledge that I have read and fully understand the risks associated with the e-mail communication between Boys Town and me. I consent to the conditions outlined above. In addition, I agree to these guidelines, as well as any other conditions or guidelines that Boys Town Behavioral Health may impose to communicate with e-mail recipients by e-mail. Any questions I had were answered.

\_\_\_\_\_  
Print Client Name  
(If a minor, person authorized to sign for Client)

\_\_\_\_\_  
Signature of Client  
(if a minor, person authorized to sign for Client)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

Providing a valid email address below authorizes e-mail communication between the Client or Legal Guardian listed above and the client's therapist.

All other authorizations regarding e-mail communication with interested third parties require completion of Behavioral Health Clinic Authorization to Release Confidential Information.

Name of Client: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of email recipient: \_\_\_\_\_  
Email Address: \_\_\_\_\_

## Pretreatment Questionnaire

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Gender:  M  F

Race:  American Indian or Alaska Native  Asian  Black or African American  White  
 Native Hawaiian or Other Pacific Islander  Other  Decline to Answer

Ethnicity:  Hispanic or Latino Origin  Not Hispanic or Latino Origin  Decline to Answer  Unknown

Form completed by: \_\_\_\_\_  Self  Parent  Legal Guardian

Referred by: \_\_\_\_\_  Physician  Employer  Relative  Friend  
 Website  Other: \_\_\_\_\_

Primary concern(s) for which treatment is sought: \_\_\_\_\_

**1. Please rate yourself/your child on each of the areas below AND whether it has been a problem during the last month:**

	Extremely Poor			OK				Extremely Well		Is this a problem?	
	1	2	3	4	5	6	7	Yes	No		
Getting along with family	1	2	3	4	5	6	7	Yes	No		
Getting along with other peers/children outside of the home	1	2	3	4	5	6	7	Yes	No		
Getting along with other adults outside of the home	1	2	3	4	5	6	7	Yes	No		
Performance at school/work	1	2	3	4	5	6	7	Yes	No		

**2. Please rate yourself/your child on each of the areas below AND whether it has been a problem during the last month:**

	Never			Sometimes				Always		Is this a problem?	
	1	2	3	4	5	6	7	Yes	No		
Overactive, acts without thinking	1	2	3	4	5	6	7	Yes	No		
Sad, unhappy, down, or depressed	1	2	3	4	5	6	7	Yes	No		
Worried, nervous, and/or anxious	1	2	3	4	5	6	7	Yes	No		
Difficulties with school (academics and/or behavior)	1	2	3	4	5	6	7	Yes	No		
Sleeping problems	1	2	3	4	5	6	7	Yes	No		
Problems with temper, having a 'short fuse'	1	2	3	4	5	6	7	Yes	No		
Difficulty tolerating frustration/change	1	2	3	4	5	6	7	Yes	No		
Problems with peers	1	2	3	4	5	6	7	Yes	No		
Other: _____	1	2	3	4	5	6	7	Yes	No		
Other: _____	1	2	3	4	5	6	7	Yes	No		

**Clinician Use:**  Int  Ext  Comb  Oth;

**Individuals living with you/your child:**

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

**Divorced/Separated/Not Living Together:**  Yes  No If yes, please note above who (adults and children) lives with your child in each residence. Also, please describe current parenting schedule/time spent in each household:

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

**Educational history:**

Current school: \_\_\_\_\_ Current grade: \_\_\_\_\_  
Special education placement?  Yes  No If yes, in what area?  
Has the school performed psychological testing?  Yes  No If so, when?  
Is there an IEP (Individual Educational Plan)?  Yes  No  Don't know

**Your/your child's interests/activities:** \_\_\_\_\_

\_\_\_\_\_

**Your/your child's strengths:** \_\_\_\_\_

\_\_\_\_\_

**Previous mental health treatment:**  None  Yes (please detail below)

Mo/Yr \_\_\_\_\_ Provider \_\_\_\_\_ Treatment \_\_\_\_\_ Outcome \_\_\_\_\_  
Mo/Yr \_\_\_\_\_ Provider \_\_\_\_\_ Treatment \_\_\_\_\_ Outcome \_\_\_\_\_

**Current legal concerns:**  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Past history of abuse:**  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Religious/spiritual affiliation(s):** \_\_\_\_\_  None  Prefer not to answer

**Developmental history:**

Complications at birth or in early childhood?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Medical diagnoses and conditions:**  None  Other: \_\_\_\_\_

\_\_\_\_\_

**Significant operations/invasive procedures:**  None  Other: \_\_\_\_\_

\_\_\_\_\_

**Serious injuries/chronic illnesses/hospitalizations:**  None  Other: \_\_\_\_\_

\_\_\_\_\_



**Last visit to doctor/well-check date:** \_\_\_\_\_ **Doctor's name:** \_\_\_\_\_

**Allergies:**  None  Other: \_\_\_\_\_

**Immunizations current?**  Yes  No If no, please explain: \_\_\_\_\_

**Medications (prescribed and over-the-counter):**  None

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Prescribing Physician \_\_\_\_\_ Started \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Prescribing Physician \_\_\_\_\_ Started \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Prescribing Physician \_\_\_\_\_ Started \_\_\_\_\_

Date of last medication check? \_\_\_\_\_

**Adverse drug reactions:**  None  Other: \_\_\_\_\_

**Substance use:**

**Alcohol use:**  None  Suspected  Known to use currently  Recovering

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ How often? \_\_\_\_\_

**Drug use:**  None  Suspected  Known to use currently  Recovering

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ How often? \_\_\_\_\_

**Parent/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_