NAME: _____

Jamestown Psychiatric, P.C.

237 Delaware Avenue
Olean, New York 14760
(716) 790-8847

1465 Foote Avenue Ext.
Jamestown, New York 14701
Phone 716) 526-4041 Fax (716) 526-4161

20 Gillis Avenue
Ridgway, PA 15853
(814) 772-5741

www.jamestown.psychwebmd.com info@psychwebmd.com

NAME: _____

NEW CLIENT INTAKE FORM

Jamestown Psychiatric, PC would like to thank you for choosing our services. We look forward to a productive relationship with you by providing the best quality mental health care to meet your individual needs. Our first new patient appointment may be scheduled out between 2-3 weeks. If at any time you feel you cannot wait until then, or you have thoughts of self-harm or of harming someone else, please go directly to the nearest hospital and a counselor there will assess you for further help. Please complete this Adult New Client Intake Form completely so that we understand you better.

DATE COMPLETED: _____

OFFICE LOCATION REQUESTED: _____ JAMESTOWN _____ OLEAN _____ RIDGWAY

DEMOGRAPHICS:

NAME: _____

HOW DO YOU WANT TO BE ADDRESSED : _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ MOBILE PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

SEX: _____ HEIGHT: _____ WEIGHT: _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

PREFERRED METHOD OF CONTACT: HOME PHONE _____ MOBILE PHONE_____ HOME PHONE _____EMAIL

APPROVED METHODS OF CONTACT: _____TEXTS _____ VOICE MESSAGES _____ EMAILS

EMERGENCY CONTACT'S NAME: _____

RELATIONSHIP TO THE CLIENT: _____PHONE: _____

NAME: _____

FINANCIAL INFORMATION: COPY OF ALL INSURANCE CARDS ARE REQUIRED

CLIENT'S RESPONSIBILITY TO ASSURE THAT THE MOST UPTODATE INSURANCE INFORMATION IS PROVIDED.

*__PRIMARY INSURANCE__: _____

INSURANCE ID #: _____ INSURANCE GROUP #: _____

GUARANTOR'S NAME (Person responsible for Insurance & payments): _____

PATIENT'S RELATIONSHIP TO GUARANTOR: _____

GUARANTOR'S DATE OF BIRTH: _____ PHONE: _____

GUARANTOR'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT YOUR INSURANCE AND ASK ABOUT PRIOR AUTHORIZATION REQUIREMENTS FOR VISITS FOR CPT CODES: (99204, 99205, 99213, 99214). IS A PRIOR AUTHORIZATION REQUIRED: YES____ or NO ____

*__SECONDARY INSURANCE__: _____

INSURANCE ID #: _____ INSURANCE GROUP #: _____

GUARANTOR'S NAME (Person responsible for Insurance & payments): _____

PATIENT'S RELATIONSHIP TO GUARANTOR: _____

GUARANTOR'S DATE OF BIRTH: _____ PHONE: _____

GUARANTOR'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT YOUR INSURANCE AND ASK ABOUT PRIOR AUTHORIZATION REQUIREMENTS FOR VISITS FOR CPT CODES: (99204, 99205, 99213, 99214). IS A PRIOR AUTHORIZATION REQUIRED: YES____ or NO ____

I understand that any and all non-covered claims for services rendered and any balance is totally the client's / guarantor's responsibility and will be paid in a timely manner.

Signature: _____

NAME: _____

MENTAL HEALTH AND SUBSTANCE USE HISTORY:

PAST HISTORY OF MENTAL HEALTH DIAGNOSES:

_____

_____

PAST MENTAL HEALTH PROVIDERS, FACILITIES AND LOCATIONS:

_____

_____

COUNSELOR'S NAME - _____

PHONE: _____ FAX: _____

DO YOU HAVE A HISTORY OF ATTEMPTED SUICIDE ATTEMPTS: GIVE DETAILS

_____

_____

DO YOU HAVE A SUBSTANCE USE HISTORY (ALCOHOL USE, DRUG USE,NICOTINE USE): GIVE DETAILS

_____

_____

WOULD YOU LIKE TO RECEIVE SMOKING CESSATION INFORMATION? _____

WOULD YOU LIKE A REFERRAL FOR SUBSTANCE TREATMENT? _____

MEDICAL HEALTH HISTORY:

PRIMARY CARE DOCTOR: _____

PHONE: _____ FAX: _____

PAST HISTORY OF MEDICAL DIAGNOSES:

_____

_____

PAST MAJOR EVENTS OR HOSPITALIZATIONS:

_____

_____

DO YOU HAVE ANY KNOWN DRUG, FOOD OR ENVIRONMENTAL ALLERGIES: (ALLERGEN'S NAME AND REACTION):

_____

_____

NAME: _____

MEDICATION HISTORY:

CURRENT MEDICATIONS:
LIST BELOW THE NAMES OF ALL CURRENT MEDICATIONS (PRESCRIBED, OVER THE COUNTER, HERBALS, VITAMINS, RECREATIONAL) INCLUDING STRENGTH (DOSE), TIMES TAKEN EACH DAY, DATE STARTED, AND THE PRESCRIBING PROVIDER'S NAME: (USE EXTRA PAPER IF NEEDED)

_____
_____
_____

PAST MENTAL HEALTH MEDICATIONS :
LIST BELOW THE NAMES OF ALL PAST MENTAL HEALTH MEDICATIONS (PRESCRIBED, OVER THE COUNTER, HERBALS, VITAMINS, RECREATIONAL) INCLUDING STRENGTH (DOSE), TIMES TAKEN EACH DAY, DATE STARTED, DATE ENDED, THE REASON FOR ENDING IT AND THE PRESCRIBING PROVIDER'S NAME: (USE EXTRA PAPER IF NEEDED)

_____
_____
_____

PREFERRED PHARMACY TO USE: _____ PHONE #: _____

ADDRESS: _____

SAFETY CHECK:

DO YOU HAVE ADVANCED DIRECTIVES – (I.E. HEALTH CARE PROXY, DNR) _____

DO YOU FEEL SAFE IN YOUR HOME ENVIRONMENT? _____

DO YOU HAVE ACCESS TO GUNS OR OTHER WEAPONS? _____

ARE YOU ABLE TO TAKE CARE OF YOUR ACTIVITIES OF DAILY LIVING, CLEANING, COOKING, AND FINANCES?

_____
(IF NO, GIVE DETAILS)

DO YOU HAVE A GOOD SUPPORT SYSTEM? (I.E. FAMILY, FRIENDS) _____

FAMILY MENTAL HISTORY:

FAMILY'S MENTAL HEALTH HISTORY:

_____
_____

FAMILY'S HISTORY OF ATTEMPTED OR COMPLETED SUICIDE ATTEMPTS:

_____
_____

NAME: _____

CONSENT FOR CREDIT CARD USE - **THIS SECTION MUST BE COMPLETED & SIGNED**:

INFORMATION TO BE COMPLETED BY CREDIT CARD HOLDER: The undersigned agrees and authorizes Jamestown Psychiatric, P.C.to use my credit card for the new client no show appointment fee if applicable at the time of the missed appointment.

CLIENT'S NAME: _____

CREDIT CARD HOLDER'S AUTHORIZED NAME: _____

(AS IT APPEARS ON THE CREDIT CARD)

ACCOUNT NUMBER ON CARD: _____

EXPIRATION DATE: _____ CVV: _____ BILLING ZIP CODE: _____

I, AS THE AUTHORIZED CREDIT CARD HOLDER, _____

(INSERT NAME)

authorize Jamestown Psychiatric, P.C. to process the above credit card for the new client No-Show fee. I understand this authorization will remain in effect until the completion of the New Client Appointment. I understand that this credit card will only be used for _____ 's

(INSERT CLIENT'S NAME)

account for the new client no show fee when applicable. I understand that I may also revoke this consent by submitting a written request to Jamestown Psychiatric, P.C.'s office at any future date without question.

X **Date:** _____

X **Signature of Credit Card Holder:**_____

NAME: _____

CONSENT OF CONTRACT - **THIS SECTION MUST BE COMPLETED & SIGNED:**

I (printed name) _____ by placing my signature at the bottom of this contract, I attest that the information I have provided is correct to the best of my knowledge. Jamestown Psychiatric, P.C. has offered to provide me with a complete copy of their office and HIPAA policy handouts in which I agree to abide with and understand that failure to comply may result in the dismissal from this practice. They may leave messages of discretion at the provided contact information re: appointments and call back instructions via text, email, and voice messaging. My emergency contact person may receive information on my behalf. Jamestown Psychiatric, P.C. may receive information from pharmacies regarding my medication history. Jamestown Psychiatric, P.C. may submit claims to my insurance carrier to receive payments for services rendered. I understand that any non-covered claims and any balance is totally my responsibility and will be paid in a timely manner. I consent to the credit card use for the "New No Show" appointment charge for my missed new patient appointment and understand that my credit card will be billed at the time of the missed appointment. Payments may be made via my credit card for balance due only at my request via phone, e-mail or in person unless indicated below. I have reviewed the Tele-psychiatry policy and agree to comply with it.

PLEASE SIGN BELOW INDICATING YOU ARE AWARE OF OUR POLICIES.

I . OFFICE POLICIES: (See Handout given along with your intake form also available from staff) II. NOTICE OF HEALTH INFORMATION PRIVACY PLAN ACT: (See Handout given along with your intake form also available from staff)

III. CONSENT TO TEXT, EMAIL AND VOICE MESSAGING

IV. CONSENT TO ALLOW PHARMACIES TO PROVIDE YOUR PHARMACEUTICAL HISTORY

V. CONSENT TO ALLOW JAMESTOWN PSYCHIATRIC, P.C. TO SUBMIT INFORMATION TO YOUR INSURANCE FOR BILLING

VI. CONSENT TO USE MY CREDIT CARD FOR THE MISSED "NEW NO SHOW" APPOINTMENT. VII. CONSENT FOR TELE-PSYCHIATRY USE.

X **Date**: _____

X **Signature of Client**: _____

NAME: _____

DSM-5 SELF RATED LEVEL 1 SYMPTOM MEASURE- **ADULT** -

During the last 2 weeks, how much (or how often) have you been bothered by the following problems?	NONE	SLIGHT	MILD	MODERATE	SEVERE
1. Little interest or pleasure in doing things?	0	1	2	3	4
2. Feeling down, depressed, or hopeless?	0	1	2	3	4
3. Feeling more irritated or angry?	0	1	2	3	4
4. Sleeping less than usual but still have a lot of energy?	0	1	2	3	4
5. Starting a lot more projects than usual or doing more risky things?	0	1	2	3	4
6. Feeling nervous, anxious, frightened, worried or on edge?	0	1	2	3	4
7. Feeling panic or being frightened?	0	1	2	3	4
8. Avoiding situations that make you anxious?	0	1	2	3	4
9. Unexplained aches and pains (e.g., head, back, neck)	0	1	2	3	4
10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
11. Thoughts of hurting yourself?	0	1	2	3	4
12. Hearing things other people couldn't hear, such as voices even though no one was around.	0	1	2	3	4
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
14. Problems with sleep that affected your sleep quality.	0	1	2	3	4
15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
17. Feeling driven to perform certain behaviors or mental acts repeatedly?	0	1	2	3	4
18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
19. Not knowing who you really are or what you want out of life?	0	1	2	3	4
20. Not feeling close to other people or enjoying your relationship with them?	0	1	2	3	4
21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4

NAME: _____

THE MOOD DISORDER QUESTIONNAIRE

	Instructions: Please answer each question to the best of your ability	YES	NO
1	Has there ever been a period when you were not your usual self and you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
2	Has there ever been a period when you were not your usual self, and you were so irritable that you shouted at people or started fights or arguments?		
3	Has there ever been a period when you were not your usual self and you felt much more self-confident than usual?		
4	Has there ever been a period when you were not your usual self, and you got much less sleep than usual and found you really didn't miss it?		
5	Has there ever been a period when you were not your usual self, and you were much more talkative or spoke much faster than usual?		
6	Has there ever been a period when you were not your usual self and thoughts raced through your head or you couldn't slow your mind down?		
7	Has there ever been a period when you were not your usual self, and you were easily distracted by things around you that you had trouble concentrating or staying on task?		
8	Has there ever been a period when you were not your usual self, and you had much more energy than usual?		
9	Has there ever been a period when you were not your usual self, and you were much more active or did many more things than usual?		
10	Has there ever been a period when you were not your usual self and you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
11	Has there ever been a period when you were not your usual self, and you were much more interested in sex than usual?		
12	Has there ever been a period when you were not your usual self, and you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
13	Has there ever been a period when you were not your usual self and spending money got you or your family into trouble?		
	COLUMN TOTALS	**Yes __**	**No __**
14	If you checked YES to more than one of the above, have several of these ever happened during the same period?		
15	How much of a problem did any of this cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights? Please check one response: _None _ Minor _ Moderate _ Serious		
16	Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, or uncles) had manic-depressive illnesses or bipolar disorder?		
17	Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

NAME: _____

PATIENT HEALTH QUESTIONNAIRE – 9

Over the past 2 weeks, how often have you been bothered by any of the following problems? Put only one check per item.		Not at all (0)	Several Days (1)	More than Half of the Days (2)	Nearly Every Day (3)
1.	Little interest or pleasure in doing things				
2.	Feeling down, depressed, or hopeless				
3.	Trouble falling asleep, staying asleep, or sleeping too much				
4.	Feeling tired or having little energy				
5.	Poor appetite or overeating				
6.	Feeling bad about yourself- or that you're a failure or have let yourself or family down				
7.	Trouble concentrating on things, such as reading the newspaper or watching television				
8.	Moving or speaking so slowly that other people could notice. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9.	Thoughts that you would be better off dead or of hurting yourself in some way				
	ADD TOTAL POINTS FOR EACH COLUMN:		*	**	***
	ADD TOTAL POINTS FOR THE THREE (3) ***SHADED COLUMS TOGETHER = SEVERITY SCORE TOTAL	* _____ + ** _____ + *** _____ = _____			

10.	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or to get along with other people? __ Not difficult at all __ Somewhat difficult __ Very difficult __ Extremely difficult

NAME: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ = Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people? Circle your answer:

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Scoring GAD-7: This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety 5–9: mild anxiety 10–14: moderate anxiety 15–21: severe anxiety

Form OMH 11(9-10) State of New York OFFICE OF MENTAL HEALTH

Medical & Mental Health Records Release

AUTHORIZATION FOR RELEASE OF INFORMATION FOR:

NAME: _____

ADRESS: _____

DATE OF BIRTH: _____

JAMESTOWN PSYCHIATRIC PC
1465 Foote Avenue Ext.
Jamestown, New York 14701
PHONE (716)526-4041
FAX (716)526-4161

This authorization must be completed by the patient or his/ her personal representative to use / disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrated need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: AUTHORIZATION TO RELEASE INFORMATION

DESCRIPTION OF INFORMATION TO BE USED / DISCLOSED: **Records pertaining to Mental Health History and Treatment. Records pertaining to Alcohol and Drug Chemical Dependency History and Treatment.**
Or specific information as listed: _____

PURPOSE OR NEED FOR INFORMATION:

1. This information is being requested by the individual or his / her personal representative for permission to release to a person or entity with a demonstrable need for the information.
2. The purpose of the disclosure is continuity of care.

RECORDS TO BE RELEASED FROM AND / OR RELEASED TO: (Name and Address of Facility, Person, Provider)

_____

_____

_____

_____

RECORDS TO BE RELEASED TO AND OR RELEASED FROM:

JAMESTOWN PSYCHIATRIC, P.C. 1465 FOOTE AVE EXT JAMESTOWN, NEW YORK 14701 FAX (716) 526-4161

A. I HEREBY PERMIT THE USE OR DISCLOSURE OF THE ABOVE INFORMATION TO THE PERSON, ORGANIZATION, FACILITY, OR PROGRAM(S) IDENTIFIED ABOVE. I understand that:

1. Only the information described in this form may be used and/or disclosed because of this authorization.
2. This information is confidential and is protected under the federal privacy regulations (HIPAA) and the NS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is to be disclosed to someone who is not required to comply with HIPAA, then it could be disclosed and would no longer be protected by HIPAA.
4. This information will still be protected under the NYS Mental Hygiene Law, which prohibits this information from being disclosed by anyone who receives it unless the disclosure is permitted by the NYS law. (Mental Hygiene Law s33.13)
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the person I have authorized to use and/or disclose my protected health information has on already acted upon because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from JAMESTOWN PSYCHIATRIC PC.
6. I have the right to inspect and receive a copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations (found under 45CFR s164.524 and NYS Mental Hygiene Law s33.16.)

Inspection and review of your health information will be done in the presence of the provider so that explanation of terms may be given.

B-1. ONE-TIME USE/DISCLOSURE: I hereby permit the one-time use or disclosure of the information described above to the person, organization, facility, or program identified above.
My authorization will expire on: ((Select one) ☐ When acted upon; ☐ 90 days from this date ☐ Other

B-2. PERIODIC USE OR DISCLOSURE: I hereby authorize the periodic use or disclosure of the information described above to the person, organization, facility, or program identified above as often as necessary to fulfill the purpose identified above.
My authorization will expire:

(Select one) ☐ When I am no longer receiving services from JAMESTOWN PSYCHIATRIC PC ☐ On this specific date:

_____

C. **Patient's (or if under 18, the Personal Representative's) SIGNATURE IS REQUIRED:**

I certify that I authorize the use of my medical / mental health information as set forth in this document.

X: _____

Date: _____

JAMESTOWN PSYCHIATRIC, P.C. APPOINTMENT POLICY

Jamestown Psychiatric, P.C. has established an appointment policy to assure that each client receives the time and attention needed to obtain the qualified evaluation and diagnosis, the most effective treatment plan, and the personal counseling they require. Due to the shortage of mental health providers and the need for their services, each appointment time slot is precious. When there is late cancelation or a client does not show up for their appointment, this act ties up time that otherwise could be used to see and treat another person in need.

Your provider will establish the time frame required for your treatment. It is in the best interest for your care to attend your scheduled appointment time. This time is needed to share your progress and or concerns for continued success in your wellbeing.

- Our first "New Client" appointment may be scheduled out between 2-3 weeks. If at any time you feel you cannot wait until then, or you have thoughts of self-harm or of harming someone else, please call 911 or go directly to the nearest hospital and a counselor there will assess you for further help.

- There are two types of appointments offered at Jamestown Psychiatric, P.C, in-office, and tele-psychiatry (see Tele-Psychiatry Policy).

- A legal guardian **must** be present for clients under the age of 18 years old. Parents, caregivers, and significant others should attend appointments with the client. A Medical & Mental Health Records Release should be completed with the name and contact information of any person that would need to have access to information to assist in care.

- Insurance information and demographics must be updated upon arrival for your appointment. If you are attending a Tele-psychiatry appointment, please call the office (716) 526-4041 after your appointment to update this information and to schedule your follow up appointment.

- Payment is due and required at the time service is rendered. It is your responsibility to provide the office with up-to-date demographic and insurance information. If you are unable to make payment at the time of service, it is your responsibility to make alternate arrangements with the office. Failure to make payment or alternate arrangements may lead to dismissal from the practice and possible legal action. Returned checks due to insufficient funds will result in a $75 "Returned Check" charge to the client. If there is a financial hardship preventing you from making payments, please inquire about the "Sliding Scale Fee Discount Policy" from any staff member. (see Sliding Scale Fee Policy)

- Any treatment or medication change will be discussed **only** at your appointments. If you are having side effects, please contact the office to obtain directions and to schedule an appointment to discuss this issue. Call 911 or go to the nearest hospital for any life-threatening difficulties.

- You will receive a telephone reminder call for appointments as staff time permits. An email for your tele-psychiatry appointment will be sent from one of our staff via a psychwebmd.com email. It will include instructions and link for the appointment. This will request your response with a confirmation of the appointment, confirmation of your demographics & insurance information, and completion of the self-assessment form prior to your scheduled time. Please check your email inbox, your spam file, and in your trash. This does not replace the responsibility of the client to know of their scheduled appointments and to appear for them. If you have not received an email with the link at least 2 hours prior to your appointment, please contact the office (716) 526-4041.

- "No-show / Missed" appointments are not an acceptable way of sharing in your treatment plan. You must take responsibility for maintaining communication with the provider regarding your health and treatment. Regular attendance for appointments is **mandatory**. *The New Client no-show fee will be billed directly to the client's credit card. This credit card and authorization is documented on the New Client Packet. The charge will be $150 for a New Client No-show. Established client No-show appointments will be billed to the client at $75 and will need to be paid prior to being rescheduled.
  * The Established Client will be billed the No-show Fee for the 1st and 2nd No-show appointment. – Client must pay this fee before rescheduling.
  * Clients must understand that the **3rd No-show appointment will result in the client's discharge from the practice.** The client will be billed the No-show Fee and the client's history will be reviewed by the provider. Provisions for non-controlled medications only will be made at that time, allowing thirty (30) days for locating another provider.

- Jamestown Psychiatric, P.C. can recommend other facilities for your care. UPMC Mental Health Services (716) 664-8641, Chautauqua County Department of Mental Hygiene (716) 661-8330 or Cattaraugus County Counseling Center (716) 373-8040.

JAMESTOWN PSYCHIATRIC, P.C.'S HEALTH INSURNACANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.I.P.A.A.) HEALTH INFORMATION PRIVACY PLAN

Our Duty is to Protect Your Health Information: We are required by law to: Make sure that your health information is used in accordance with this Notice (as currently in effect) and to make available to you this Notice that describes the ways we use and share your health information as well as your rights under the law.

- We may use and share your health information in certain ways, such as when we receive your written permission, share your health information with others to help treat you, or as permitted or required by the law. The following list describes different ways that we may use and share your health information, along with examples for each.

A. Ways we are allowed to use and share your health information without your consent or as the Medical & Mental Health Records Release for Treatment, Payment, and Health Care Operations Provides:

1. **Treatment**. We may use your health information to provide you medical treatment or services. We may also share your health information with others that provide treatment to you. For example, when you receive care at a non-Jamestown Psychiatric, P.C. provider, we may share information with that provider so that they may provide care to you. We may also share your health information with others who may provide follow-up care to you, such as your primary care physician, physical therapist, long term care facility and home healthcare agencies. At all times, we will comply with any laws that apply.
2. **Payment.** To receive payment for the services we provide to you, we may use and share your health information with your insurance company or a third party who is paying for your care. We also may share your health information with other health care service or product providers who need to pre-approve or provide follow-up care to you, such as your physicians, other providers, EMS providers, nursing homes and home care agencies so they can bill you, your insurance company, or a third party. For example, some health plans require your health information to pre-approve you for surgery and require preapproval before they pay us.
3. **Health Care Operations.** We may use and share your health information for business and other operational purposes. For example, we may use your health information to evaluate the quality of the treatment that we provided. We may share your health information with our researchers, so they can develop plans to conduct research. We may share information with our students, trainees, and staff for review and training purposes. We may share your health information for case management and care coordination purposes. However, we will not sell your name or any identifiable health information to others without your authorization.
4. **Business Associates.** We may share your health information with others called "business associates," who perform services on our behalf. The Business Associate must agree in writing to protect the confidentiality of your health information. For example, we may share your health information with a billing company that bills for the services that we provided.
5. **Appointment Reminders.** We may use and share your health information to remind you of your appointment for treatment or medical care. For example, we may call, text, or e-mail you to remind you of a scheduled appointment. We may also use and share your health information to confirm the time, place, and attendance of your appointment for treatment with third-party transportation services.
6. **Treatment Options and Other Health-Related Benefits and Services.** We may use and share your health information to tell you about treatment options and other health-related benefits and services. For example, if you suffer from a chronic illness or condition, we may use your health information to assess your eligibility and propose newly available treatments.
7. **Special Situations.** In the following situations, the law either permits or requires us to use or share your health information with others. However, laws governing sensitive information (including behavioral health information, drug and alcohol treatment information, and HIV status) may limit these disclosures.
    a. **As Required by Law.** We may share your health information when required or permitted by federal, state, or local law. For example, if we believe that you have been a victim of abuse, neglect, or domestic violence, we may share your health information with an authorized government agency. If we share your health information for this purpose, we will tell you unless we believe that telling you would put you or someone else at risk of harm.
    b. **To Prevent a Serious Threat to Health or Safety.** We may use and share your health information with persons to prevent or lessen the threat of serious harm to the health and safety of you, the public, or another person. State laws may require such disclosure when an individual or group has been specifically identified as the target or potential victim.
    c. **Organ and Tissue Donation.** To assist in the process of eye, organ, or tissue transplants in the event of your death, we may share your health information with organizations that obtain, store, or transplant eyes, organs, or tissue.
    d. **Special Government Purposes.** We may use and share your health information with certain government agencies, such as:
        - **Military and Veterans.** We may share your health information with military authorities as the law permits if you are a member of the armed forces (of either the United States or a foreign government). **National Security and Intelligence.** We may share your health information with authorized federal officials for intelligence, counter- intelligence and other national security activities authorized by law.
        - **Protective Services for the President and Others.** We may share your health information with authorized federal officials to protect the President of the United States, other authorized persons, or foreign heads of state. We may also share your health information for purposes of conducting special investigations as authorized by law.
    e. **Workers' Compensation.** We may share your health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.
    f. **Public Health.** We may share your health information with public health authorities for public health purposes to prevent or control disease, injury, or disability. This includes, but is not limited to, reporting disease, injury, and important events such as birth or death, and conducting public health monitoring, investigations, or activities. For example, we may share your health information to 1) report child abuse or neglect; 2) collect and report on the quality, safety, and effectiveness of products and activities regulated by the Food and Drug Administration (FDA) (such as drugs and medical equipment, and could include product recalls, repairs, and monitoring); or 3) help contain the spread of a disease.
    g. **Health Oversight.** We may share your health information with a health oversight agency for purposes including 1) monitoring the health care system; 2) determining benefit eligibility for Medicare, Medicaid, and other government benefit programs; and 3) monitoring compliance with government regulations and laws.

h. **Coroners, Medical Examiners, and Funeral Directors.** We may share your health information with a coroner or medical examiner to identify a deceased person, determine the cause of death, or for other reasons allowed by law. We also may share your health information with funeral directors, as necessary, so they can carry out their duties.

i. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may share your health information with the correctional institution or law enforcement official. This would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution and its staff.

B. Other Ways We Are Allowed to Use and Provide Your Health Information to Others:

1. **People Involved in Your Care or Payment for Your Care.** We may share your health information with a friend, family member, or another person identified by you who is involved in your medical care or the payment of your medical care. We may share your health information with others if you are present or available before we share your health information with them and you do not object to our sharing your health information with them, or we reasonably believe that you would not object to this. If you are not present and certain circumstances indicate to us that it would be in your best interests to do so, we will share information with a friend or family member, to the extent necessary. This could include sharing information with your family or friend so that they could pick up a prescription or a medical supply. We may tell your family or friends that you are in at our office in an emergency. We may share medical information about you with an organization assisting in a disaster relief effort.
2. **Permissible Disclosures to Law Enforcement.** We may share your health information with a law enforcement official or authorized individual:
    a. In response to a court order, subpoena, warrant, summons, or similar process.
    b. To identify or locate a suspect, fugitive, material witness, or missing person.
    c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
    d. About a death we believe may be the result of criminal conduct.
3. About criminal conduct at the office, or 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.
4. **Exception to the Above.** If you are a patient in a psychiatric/mental/behavioral health facility or drug and alcohol facility, additional authorization may be required to release your information outside of Jamestown Psychiatric, P.C. Subject to laws that allow certain minors to consent to medical treatment, this permission must come from your parents or legal guardians.

C. **Where Written Permission is Required**

Except as stated in Sections A and B, your written permission is required before we can use or share your health information with anyone outside of Jamestown Psychiatric, P.C. If you give us permission to use or share your health information, you may cancel that permission, in writing, at any time. However, this does not apply to health information that we have already shared with your permission. The law gives you the following rights about your health information:

1. **Right to Ask to See and Request a Copy.** You have the right to ask to see and request a copy of the health information we used to make decisions about your care. This includes your right to request a copy of your electronic medical record in electronic form. Your request must be in writing. You can contact us by email to info@psychwebmd.com , mail to Advance Practice Solutions at 1465 Foote Avenue Ext. Jamestown, New York 14701, or fax at716-526-4161. If you ask to see or request a copy of your health information, you may have to pay fees as permitted by law. If we are concerned that your request may impact your care, we may tell you that you cannot see nor have a copy of some or all your health information. If we tell you this, you may ask that someone else at Jamestown
Psychiatric, P.C. review this decision. A licensed health care professional chosen by Jamestown Psychiatric, P.C. will review those that can be reviewed. This person will not be the same person who refused your request.
2. **Right to Ask for a Correction.** If you feel that the health information that we have about you is incorrect or incomplete, you may ask us to correct the information. You have the right to ask for a correction for as long as the information is kept by or for Jamestown Psychiatric, P.C. You must put your request in writing and give it to your doctor or the place where you received care. If you do not ask in writing or give your reasons in writing, we may tell you that we will not make the change. We also have the right to refuse your request if 1) we determine that the information is correct and complete; 2) the information is not part of the health information created or kept by or for Jamestown Psychiatric, P.C. 3) the person or place who created the information is no longer available to make the correction and we believe the information to be correct; or 4) the information is not part of the information that you are permitted by law to see and/or copy.
3. **Right to Ask for an "Accounting of Disclosures."** You have the right to ask us for an "accounting of disclosures." This is a list of those people and organizations who have received or have accessed your health information. This right does not include information made available for treatment, payment, or health care operations, or made available when you have provided us with permission to do so. You must put your request in writing and give it to your doctor or the place where you received care. You can call your doctor's office or the place where you received care to find out how to ask for the list. You must include in your written request how far back in time you want us to go, which may not be longer than six years.
4. **Right to Ask for Limits on Use and Sharing.**
    a. **Generally.** You have the right to ask us to limit the health information we use or share with others about you for treatment, payment, or health care operations. You also have the right to ask us to limit health information that we share with someone who is involved in your care or payment for your care, like a family member or friend. You can call your doctor's office or the place where you received your care to get instructions on how to submit such a request. 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) the person or institution the limits apply to (for example, your spouse). For example, you could ask that we not use or share information about a surgery you had. You must put your request in writing and give it to your doctor or the place where you received your care. We are not required to agree to your request. If we do agree to your request, we still may provide information, as necessary, to give you emergency treatment.
    b. **Services Paid for by You.** Where you have paid for your services out of pocket in full, at your request, we will not share health information about those services with a health plan for purposes of payment or health care operations. "Health plan" means an organization that pays for your medical care.
5. **Right to Ask for Confidential Communications.** You have the right to ask that we contact you about your health information in a certain way or at a certain location that you believe provides you with greater privacy. For example, you can ask that we contact you at work or by mail. Your request must state

how or where you wish to be contacted. You must make your request in writing to your doctor or the place where you received care. You do not need to provide a reason for your request. We will comply with all reasonable requests.

6. **Right to Ask for a Paper Copy of This Notice.** You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically (for example, through the computer), you still have the right to a paper copy of this Notice. You can also get a copy of this Notice at our website. To obtain a paper copy of this Notice, contact us via email to info@psychwebmd.com , by mail to Advance Practice Solutions at 1465 Foote Avenue Ext. Jamestown, New York 14701, by fax to 716-526-4161 or at the office or the registration department of the place where you received care.

Violation of Privacy Rights: If a breach of your health information occurs at Jamestown Psychiatric, P.C. or one of its Business Associates, you will be provided with written notification as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations.

If you believe your privacy has been violated by us, you may file a confidential complaint directly with us. You can do this by contacting the Jamestown Psychiatric, P.C.'s Privacy Officer at the office email or by email to sandi@psychwebmd.com , by mail to Advance Practice Solutions at 1465 Foote Avenue Ext. Jamestown, New York 14701 or by fax to 716-526-4161. You will not be penalized for filing a complaint.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary of Health and Human Services, you must 1) name the Jamestown Psychiatric, P.C. place or person that you believe violated your privacy rights and describe how that place or person violated your privacy rights; and 2) file the complaint within 180 days of when you knew or should have known that the violation occurred. All complaints to the Secretary of the U.S. Department of Health and Human Services must be in writing and addressed to **U.S. Department of Health and Human Services** **200 Independence Ave. S.W.**

Washington, DC 20201

Changes to This Notice

We reserve (have) the right to change this Notice. We reserve (have) the right to make the revised or changed Notice effective for health information we already have about you and for any future health information. We will post a copy of the revised Notice in the places where we provide services and on our website. The Notice will contain the effective date. We will provide to you, if you ask us, a copy of the Notice that is currently in effect. • Inquiries, questions, and requests for more information about policies, costs and fees may be given to any staff member via phone (716) 526-4041, via email sandi@psychwebmd.com, via Fax (716) 526-4161 or via USPS to 1465 Foote Avenue Ext. Jamestown, New York 14701.

JAMESTOWN PSYCHIATRIC, P.C. TELE-PSYCHIATRY POLICIES AND PROCEDURE

Jamestown Psychiatric, P.C. offers Tele-psychiatry as an option of providing services to clients – that otherwise would be unable or difficult to receive treatment in a more conventional way, connecting with client's responsible party if unable to be present in person, a venue for acquiring and providing consultation services and a method of assisting the provider with obtaining information, documenting the required information into the client's chart and providing any assistance needed by virtual scribes, staff and personnel.

Tele-psychiatry is defined as the use of two-way real time-interactive audio and video equipment to provide and support certain psychiatric and addiction services at a distant site. These services can include evaluations, testing, treatment discussions, medication management, counseling, and transfer to a higher level of care, recovery follow ups and discharges.

All of Jamestown Psychiatric, P.C.'s Tele-psychiatric technology is compliant with confidentiality standards set forth by federal laws. Jamestown Psychiatric, P.C's policies and procedures include guidelines for: -Psychiatric provider requirements:

- All of Jamestown Psychiatric, P.C. providers must adhere to the requirements of their title, set forth by New York State, any other state licensed in and the federal government. These requirements include but are not limited to licensure, CME, health assessments and immunizations.
- All providers may only provide services that have been designated in their professional licensure, set forth by New York State, any other state licensed in and the federal government.
- The provider must be actively licensed in the state (distant site) in which the Tele-psychiatry client is located at the time of the appointment.
- Jamestown Psychiatric, P.C providers must fulfill all contractual responsibilities and provide satisfactory documentations on all clients being seen via Tele-psychiatry (same as in-office appointments) required by the Medicare, Medicaid or third-party insurance regulations. These documentations must be done in a timely manner.

-Establishing the need and the condition of the person receiving the Tele-psychiatry service:

- Tele-psychiatry is utilized for the need of providing psychiatric care to a client that may not be otherwise able to obtain care due to under-served psychiatric care areas, medical conditions, or psychiatric symptoms preventing public interaction and have a great distant to travel to continue care. It also provides continuity of care for those needing continual treatment but have moved away, attend college or whose schedules do not allow for time away to attend to appointments.
- Tele-psychiatry services are offered to established and stable private clients for evaluations, medication management and condition updates. The case is reviewed with the client's provider, responsible party for the client and the nursing staff (or anyone involved with the client with knowledge of the client's ability).
- Tele-psychiatry services are offered to established and private clients having an urgent need. The case is reviewed with the client's provider, responsible party for the client and the nursing staff (or anyone involved with the client with knowledge of the client's ability).
- Tele-psychiatry services are offered to new and established residential facility clients. The case is reviewed with the client's provider, responsible party for the client and the facilities' nursing staff (or anyone involved with the client with knowledge of the client's ability).
- Tele-psychiatry is offered to and received from other Medical and Mental Health Providers that may consult with the specialist (Psychiatrist) regarding client care or the need for immediate treatment via law enforcement or ambulance to the nearest hospital. They may also consult regarding treatment plan and actions.

-Physical Environment needed for the service:

- Location of the client utilizing Tele-psychiatry must be in an area the provider rendering care is licensed.
- The client utilizing Tele-psychiatry must have a responsible party nearby and within shouting distant. If a minor or incapacitated person, the responsible party must be present in the same room during the appointment.
- The room at both locations (distant and hub site) must be private, quiet, well lite and be void of distractions.
- The technology used must be compliant with standards, compatible and up to date. Visual and audible connections must be clear and precise. (The provider and client must be able to make a face-to-face view).

-Scheduling and assignment of the service:

- Once the need for service is made known and reviewed by the client's provider, responsible party for the client and the nursing staff (or anyone involved with the client with knowledge of the client's ability), the Jamestown Psychiatric, P.C. staff will contact the client, client's responsible party, consulting provider, facility, or office to find a convenient time for both parties. The day and time will be entered into the schedule.
- On the scheduled day, the client will be notified by email or telephone of the confidential link to the video conferencing room specified to that client for that scheduled block. They will be given the secure PIN # for access. At the specified time, the Tele-psychiatry client will be checked in (as per the in-office client policy) and all involved parties will be notified.
- At the close of the session, the provider will notify the client of the care plan and the time frame for the next appointment. The client should call the Jamestown Psychiatric, P.C. staff and a new appointment will be made.
- At the close of the Tele-psychiatry appointment, Jamestown Psychiatric, P.C. staff will change the secure PIN #.
- Documentation of all pertinent information regarding the client's history, symptoms, treatment plan and outcome of the appointment must be documented within the HIPAA approved electronic medical record (EMR) of choice by Jamestown Psychiatric, P.C. within a timely manner.

-Education and instruction of the client and or person utilizing Tele-psychiatry services:

- A copy of the Jamestown Psychiatric, P.C. **Tele-psychiatry Policies and Procedure** handout will be provided to the client.
- A simple verbal explanation will be given to the client.
- They will be informed that they will be provided with the confidential link to the video conferencing room specified to that client and the unique confidential PIN # for that scheduled block prior to the appointment time. It is the client's responsibility to review the instructions prior to the time of the appointment. The client may respond by email or phone with any question or concern and a Jamestown Psychiatric, P.C. staff member will answer them in simple instructive terms. -Informed consent:
- Assurance will be made by Jamestown Psychiatric, P.C. during the case review that the client or responsible party for the client has awareness, language skills and understanding of the Tele-psychiatry process is sufficient to make an informed consent and to participate in the Tele-psychiatry session.
- Assurance will be made during the case review with the client's provider, responsible party for the client and the nursing staff (or anyone involved with the client with knowledge of the client's ability) that the client's medical & mental health symptoms and diagnosis would not be worsened using Tele-psychiatry. (i.e., psychosis or paranoid delusions related to the use of technology)
- A **Tele-psychiatry Informed Consent** (see attached) must be signed and returned to the office, or a verbal agreement may be given to the staff. It will be maintained in the client's chart and adjusted per the client's wishes (withdrawal of consent).

-Emergency actions for technology failure:

Prior to appointment-

- The client shall receive the **Tele-psychiatry Policies and Procedure** handout with written instructions and **Tele-psychiatry Informed Consent** prior to the scheduled appointment. The Jamestown Psychiatric, P.C. staff may run a trial connection ahead of time to assure connection.
- If there are issues, another method of communication may be used to give instructions for further action by; Telephone, Laptop, iPad, iPhone, rescheduled for an in-office appointment or changed to another day and time when the client can obtain the pertinent technology.

During an appointment-

- At the beginning of the Tele-psychiatry appointment, a current location and telephone number of the client and the name and telephone number of the responsible party will be obtained for contact if tele-connection is lost.
- If an action is required, the Jamestown Psychiatric, P.C. Technology Department will be able to log into the client's computer via Team Viewer App that the client was instructed to download in the instructions. • If technology cannot be rectified, either the appointment will be completed by telephone or rescheduled.

After the appointment-

- If there is a loss of connection at the end of the appointment, the Jamestown Psychiatric, P.C. staff will telephone the client to complete the appointment under the direction of the provider (reschedule, plan or order review). The client may contact the office for assistance as needed.

-Emergency actions for crisis situations:

- If at any point during the session, there is an emergency at the end of the client, the responsible party will be notified by telephone to enter the room with the client. They will be instructed as to what to do from the provider via either Tele-psychiatry or telephone (i.e., call 911, go to the nearest hospital, remove all dangerous material, do not leave the client alone)
- If needed, Jamestown Psychiatric, P.C. staff will be notified to call the emergency system (911) and the client information will be provided (name, current location, telephone number and the reason for the emergency).
- All details will be documented in the client's chart.

-Maintaining Confidentiality and HIPAA regulations:

- All Jamestown Psychiatric, PC staff members have received a copy of the HIPAA policy and are obliged to always enforce it. This applies to all verbal & written & technology client information. Immediate dismissal of all staff members violating regulations will be strictly adhered to.
- All appointments (including in-office and Tele-psychiatry appointments) are to be carried out and executed in a private location, with closed doors, sound deterrents and in non-high traffic quiet areas at both the Originating Site and the Distant Site.
- All communication, including verbal & written & technology, including Electronic Health Records and Tele-psychiatry equipment must meet the privacy and security regulations set forth by governmental institutions of the United Sates. (45.C.F.R. Parts 160 and 164, including HITECH breach notification procedures (HIPAA) and 42 C.F.R. Part 2. These are included in the Jamestown Psychiatric, P.C. HIPAA policy. • A secure unique PIN is set for each session of Tele-psychiatry to assure confidentiality.

-Assuring quality control and advancements in available technologies:

- Jamestown Psychiatric, P.C. Technology Department will monitor the Tele-psychiatry sessions quarterly and as needed for constant improvement. Areas of review include Equipment and connectivity failures, statistics of attempted and completed Tele-psychiatry sessions, appropriateness of the use of the Tele-psychiatry program and client and provider satisfaction.
- Random Tele-psychiatry sessions will be selected and reviewed with clients.
- A complaint report will be reviewed and acted upon yearly and as needed by the Compliance Director.
- The Jamestown Psychiatric, P.C. Technology Department will continually research and develop new methods of providing the best optimal Tele-psychiatry experience possible.

Jamestown Psychiatric, P.C. Client Satisfaction Survey

Dear client: Please tell us about your experience with our services. Your opinion is very important to us. Your responses will be kept confidential. However, we will share any compliment or complaint (anonymously) directly with the staff member. Rewards or redirection for their behaviors are given appropriately. Please return to 1465 Foote Ave. Ext. Jamestown, N.Y. 14701, fax: (716) 526-4161 or email to info@psychwebmd.com. Your satisfaction of our services is very important to us. We appreciate you taking the time to complete this survey. Your information will be used to make changes or improvements as indicated. We will use this as a tool for staff training, recognition and rewards will be provided for positive remarks. Remember your care is our passion to anyone, anytime and anywhere! Thank you.

DID YOUR **PROVIDER**…(Doctor, Nurse Practitioner, and Physician Assistant):	YES	NO
1. Show a willingness to listen carefully to you?		
2. Provide a thorough explanation of your diagnosis in a way you can understand?		
3. Instruct you regarding your detailed treatment plan in a way you can understand?		
4. Provide verbal or written education material?		
5. Take the time to answer your questions?		
DID OUR STAFF…(Support Assist, Administrative Assist, RN, Clinical Manager, Office Manager):	YES	NO
1. Answer your call with courtesy, politeness and professionalism?		
2. Obtain information and provide you with a time plan for response?		
3. Respond to your call in the planned stated time frame?		
4. Greet you with professionalism when you arrived at the reception desk?		
5. Show a caring concern when obtaining your information and vitals?		
6. Provide helpful information and assistance with any treatment, billing or insurance questions?		
WAS YOUR APPOINTMENT…	YES	NO
1. Easy to schedule by phone, email or web site?		
2. Available within a reasonable amount of time?		
3. Easy to check in?		
4. Waiting time in the waiting room area within a reasonable amount of time?		
5. Was there a delay in your appointment and were you kept informed of the progress of the delay?		
WAS OUR COMMUNICATION WITH YOU…	YES	NO
1. Answered promptly?		
2. Explained in a manner which could be understood?		
3. Provided along with informational material?		
4. Via answering machine, returned in a timely manner?		
5. After hours easily accessed and responded to?		
WAS OUR FACILITY…	YES	NO
1. Hours of operation convenient for you?		
2. Atmosphere professional, comfortable, clean and overall pleasant?		
3. Parking providing adequate parking?		
4. Handicapped accessible?		
5. Directions easy to follow and easy to find?		

YOUR OVERALL SATISFACTION WITH JAMESTOWN PSYCHIATRIC, P.C.: _____

Rate us on a scale from 1–10. (1 being poor to 10 being exceptional)

ADD ADDITIONAL REMARKS: _____