



Sandia Crest Mental Health LLC

PO Box 3823

Moriarty, NM 87035

Phone: (505) 832-9135 or (505) 463-2072 Fax: (505) 212-0944

HIPPA Privacy Policy Notice and Patient Rights

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

About this Notice

This notice will tell you about the ways we may use and disclose health information that identifies you ("Health Information"). We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of Health Information that identifies you; give you this Notice of our legal duties and privacy practices with respect to your Health Information; and follow the terms of our Notice that are currently in effect. This notice covers the faculty of Sandia Crest Mental Health LLC.

We may disclose your information for the following Purposes:

For Treatment: We may use Health Information about you to provide you with medical treatment services. We may disclose Health Information to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example a physician taking care of you for a possible drug interaction may need to know what medications were prescribed for you.

For Payment: We may use and disclose Health Information so that we may bill for treatment and services you receive at Sandia Crest Mental Health LLC and can collect payment from you, an insurance company or another third party. The information often needed includes diagnosis codes, dates of services, your name, your address, your family members name that is insured, birth dates and your insurance identification numbers.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services:

We may use and disclose Health Information to contact you to remind you that you have an appointment for treatment, or to contact you to tell you about possible treatment options or health benefits and services that may be of interest to you.

Individual Involved in Your Care or Payment for Your Care:

We may release Health Information to person who is involved in your medical care or helps pay for your care, such as a family member or friend.

As Required by Law:

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

To Avert a Serious Threat to Health or Safety:

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.

Business Associates

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example we may use another company to audit our records to ensure HIPPA compliance. We may also use another company for medical billing.

Military or Veterans:

If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Law Enforcement:

We may release Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process, limited information to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises, and 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.

National Security and Intelligence Activities and Protective Services

We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We also may disclose Health Information to authorized federal officials so they may conduct special investigations and provide protection to the President, other authorized persons and foreign heads of state.

Public Health Risks:

We may disclose Health Information for public health activities. These activities generally include disclosures to: a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of and FDA-regulated product or activity; prevent or control disease, injury or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make such disclosure.

Health Oversight Activities:

We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Other Uses of Health Information:

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written permission. You may revoke your permission at any time by submitting a written request to our Privacy Officer, except to the extent that we acted in reliance on your permission.

Your Rights Regarding Health Information about you

You have the following rights, subject to certain limitations, regarding Health Information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information and you must tell us the reason for your request. You have the right to request an amendment for as long as the information is kept by or for Sandia Crest Mental Health LLC. A request for amendments must be submitted, in writing, to the Privacy Officer at the address at the top of this notice.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" of Health Information. This is a list of certain disclosures we made of Health Information. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the lists.

Right to Request Restrictions

You have the right to request restrictions or limitations on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment or your care, likely a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you may request that we contact you only by mail.

Right to a Paper copy of this Notice

You have the right a paper copy of this Notice, even if you have agreed to receive this notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this notice, send your request, in writing, to our Privacy Office at the address listed above. Alternatively, to exercise your right to inspect and copy Health Information, you may contact your clinician office directly.

Your responsibilities

As a client, you also have some responsibilities to yourself, to other clients and to the center/clinic. Read about them carefully and be sure to ask your provider if you have any questions about them.

Client has the responsibility:

- To participate in the development of your treatment plan
- To provide the best of his/her knowledge, accurate and complete information about: present complaints, past illnesses, hospitalizations, medications, advanced directives and other matters relevant to care.
- To adhere to TCC/SCMH LLC policies and procedures including those regarding weapons and safety
- To attend sessions sober
- To notify TCC/SCMH LLC providers of change of condition
- To follow his/her individual treatment/care plan
- To notify TCC/SCMH LLC providers if treatment/care plan or schedule needs to be changed
- To inform TCC/SCMH LLC providers of any problems or dissatisfactions with the services provided.
- To carry out mutually agreed upon responsibilities
- To meet financial obligation and commitment
- To treat providers with dignity and respect

- To provide a safe environment for care to be provided when such care is being provided in his/her private home
- To notify TCC/SCMH LLC provider if another provider has changed medications or is involved in your mental health care.
- To notify clinician at least 24-48 hours prior to your appointment if you cannot make your scheduled appointment.

Consent for Treatment:

I understand that the primary staff person(s) assigned to me will explain the nature of treatment to be provided, the expected benefits and risks, and alternatives available. I also understand that although a reasonable standard of care will be provided, improvement, though expected is not guaranteed. If I wish to withdraw from treatment at any time a staff person will help me with an appointment referral. If I refuse care or treatment, a staff person will inform me of the foreseeable risks associated with such refusal of care or treatment.

Confidentiality and Release of Information:

I understand that the information concerning my contacts with the program will be held confidential to protect my right to privacy. I further understand that such information will not be disclosed without my written consent or that of my legal guardian, except under special circumstances such as:

- If I threaten to injure my self or someone else, or,
- When such information is required by law to be reported, such as information regarding abuse, neglect, molestation, or exploitation of a minor, incapacitated adult, elder person 65 or older, or incase of a court order, or,
- Pertinent parts of my medical record and/or financial records pertaining to my treatment for the purpose of quality improvement activities.



TITLE: RELEASE OF PATIENT INFORMATION – PATIENT ACCESS

POLICY:

All information contained within a patient's medical record or as accessed via computerized systems will be maintained in a confidential manner to protect the patient's right to confidentiality and comply with City, State and Federal Regulations including HIPAA.

Sandia Crest Mental Health LLC shall honor a patient's request to send medical information to another physician, hospital, or medical facility; to an attorney; to an insurance company; and to the patient

Protected Health Information (PHI) may only be *accessed/released* (disclosed) as follows:

- to those directly involved in the care of the patient;
 - for the protection of public health as provided by law;
 - for the payment of services as authorized by the patient;
 - to assist researchers as authorized by the patient or other legally authorized individuals;
 - or for any other purposes authorized/or required by law;
- Or, authorized by the patient or other legally authorized individual/or entity.

Protected health information may be disclosed with the authorization of the patient if:

- The authorization is in writing, is dated, and is signed or otherwise authenticated;
- The authorization specifies the information to be disclosed;
- The authorization specifies the entity or location to disclose the information; and
- The authorization specifies the person or persons to receive the information.

PROCEDURES:

1. The following procedures apply to the release of information process:
 - Patients or designated individuals requesting access to their medical information shall complete an Authorization to Release Medical Information form. Attorneys requesting access to medical records is required to have the patient complete the New Mexico State approved Release of Protected Health Information form.
 - The signature on the authorization must be that of the patient or legal representative (e.g. executor/executrix) if the patient is deceased, or of the legal guardian if the patient is a minor or has been declared incompetent. The Authorization to Release Medical Information form and the medical record should be reviewed to assure that the signature of a person matches the documentation in the medical record.
 - The date on the authorization must be no more than one year old.
 - In an emergency situation, a healthcare provider can read or fax medical information to a physician, hospital, or medical facility upon receipt of the required authorization or a statement on the letterhead of the organization indicating that the patient is unable to sign.
 - Medical information may be released and/or shared with another healthcare provider / healthcare organization without a signed authorization if the healthcare providers have a patient in common or for continuity of care. Examples of this include: a physician who refers a patient for a specialty consults. The consult would be expected to share a report of their findings with the referring physician. Another example includes providing information to a homecare agency when referring a patient to a homecare agency.
 - According to New Mexico State Law "...a subject over the age of 14 may be notified of any request by a qualified person to review his/her patient information, and, if the subject objects to disclosure, the provider may deny the request..."
 - Medical records will be copied and forwarded within 10 business days of receipt of a written request for such information.
 - Sandia Crest Mental Health may charge \$175.00 or \$10.00 per page for copies of patient medical information. In cases where the patient states in writing that he/she cannot afford to pay for their records, the \$175.00 charge may be waived. Receipt of payment (or non-receipt of payment) will not affect request response.
2. **Research** Staff identified as participating in research programs approved by the Institutional Review Board (IRB) may have access to medical records as necessary for the conduct of the research protocol. If there are questions about the information requested, the Principal Investigator will provide a copy of the approved protocol. All researchers must also comply with the Research and HIPAA policy available on the HIPAA web site. Researcher access to protected health information is limited to the scope approved by the IRB. It is the responsibility of the Principal Investigator to comply with all HIPAA and Research policies for data access and use.
3. **Attorneys, Insurance Companies, Third Party Payors**
Upon presentation of proper authorization from the patient, a parent or guardian, or the executor of the estate of a deceased patient; attorneys, third party payors, and others having legitimate interest in the medical record of patient may have information from the record.
4. **Law Enforcement Agencies**
Members of the FBI or police department who request medical information in the absence of proper documentation must be referred to the Privacy Officer.
5. **Subpoenas for Medical Records**
Any department or healthcare provider receiving a subpoena for medical records is encouraged to forward it to the Privacy Officer for review and approval prior to processing the request.
6. **Mental Health Record**
Mental Health Records require the approval of the mental health provider or their designee. If in the opinion of the physician it is felt that the information may be harmful to the patient or others, the provider may deny access to the information. This opinion must be stated in writing in the medical record. In addition, the patient has the right to appeal this decision with the NM Office of Mental Health



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HIPPA Privacy Policy Notice and Patient Rights and Responsibilities

By signing this statement I acknowledge that I have received a copy of Sandia Crest Mental Health LLC HIPPA Privacy Policy Notice and Patients Rights and Responsibilities, confidentiality and release of information statement. Furthermore, I acknowledge that I have read and understand the policy and my rights, responsibilities, confidentiality statement and release of information.

Initial _____ Date _____

Financial Agreement Consent

I have received a copy of the financial agreement and understand my financial obligation. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable I will not be charged for the canceled session.

Initial _____ Date _____

Treatment Consent

By signing this agreement I give my permission to receive behavior health treatment that may include psychopharmacology management and or psychotherapy. I understand there are benefits and risks of taking medications and if I have questions I will ask the clinician prescribing to explain the risk, benefits and side effects. I agree to disclose information regarding my health status as I recognize this may affect the outcomes of taking behavioral health medication. I agree to take medication as prescribed and to inform my provider of benefits and or side effects that I may experience.

Signature _____ Date _____

Print Name _____



Client's Information

Client's Name _____ (Please include First, Last and Middle Initial)

SSN: _____

Medicaid #: _____ DOB _____

Street Address _____ City: _____ State _____ Zip Code _____

Mailing Address (if different from above) _____ City: _____ State: _____

Zip Code _____ Home Phone _____ Cell Phone _____

Circle One Status: Single Married Divorced Separated Widowed Male or Female

Employer: _____ Address: _____

City: _____ NM: _____ Phone: _____

Email _____ Insurance Name _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone #: _____ Member ID # _____ Group ID # _____

Responsible Party /Insured Information if different from above

Insured Holder's Name: _____ (Please include First, Last and Middle Initial)

Relationship: _____ SSN: _____ Drivers License# _____ State: _____

Expiration: _____

DOB: _____ Address _____ City _____ State _____

Phone _____ Cell Phone _____ Individual ID: _____

Group ID _____ Prior Authorization: _____

Emergency contact: _____ Phone: _____

To the best of my knowledge I attest the information above is true and correct. I understand Sandia Crest Mental Health LLC does not bill secondary insurance companies. As parent or legal guardian of the above client, I authorize evaluation and treatment by Sandia Crest Mental Health(SCMH) LLC. As parent or legal guardian, I gave the right to request information concerning the above minor's evaluation by completion of a release form. The above information is true to the best of my knowledge. I authorize insurance benefits to be paid directly to SCMH LLC. I understand that I am financially responsible for any balances due to SCMH LLC (by collection of any means) if any claim should be denied as not covered or is not eligible for benefits. I hereby acknowledge and authorize SCMH LLC to use and disclose any information necessary based on the



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Financial Agreement

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible and /or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of the monthly statement. I understand that Sandia Crest Mental Health LLC services does not initiate billing to an insurance that is secondary. They only bill to the primary insurance company. I am responsible for activating & billing any secondary insurance coverage and for obtaining any necessary pre-authorization &/or treatment plan submission requirements for secondary insurance coverage. It is also my responsibility to review the Explanation of Benefit (EOB) forms I receive from my insurance so I can track insurance payment for services rendered.

I understand that my insurance claims will be sent electronically via computer modem to a third party billing insurance electronic portal. SCMH LLC will direct insurance claims to my insurance company electronically where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and dates fo my mental health treatment sessions. By my signature on the HIPPA consent form under financial agreement, I am giving Sandia Crest Mental Health LLC (SCMH LLC) permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies. Furthermore, I authorize that payment of mental health/ chemical dependency benefits be made to Sandia Crest Mental Health LLC. Any questions that I have about confidentiality can be answered in the Notice of Privacy Practices given at the initial appointment. I have also signed the HIPPA acknowledgement form and understand my client rights and rules regarding release of Protected Health Information. I have been informed that I can ask the Privacy Officer any questions regarding confidentiality of records, the compliant procedure, or other matters pertaining to my review of my record.

Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangement for prompt payment of bill.

*Certain special services (e.g. school evaluations , school interventions, report writing, some types of testing, court-ordered treatment/evaluation) are often not covered by insurance. It is the clients responsibility to determine what services are and are not covered by their health insurance. If you are being seen for any services other than psychotherapy and psychiatric medication management it is strongly recommended you call your insurance carrier to verify coverage.

*If you become involved in any legal matter that requires your therapist to testify in Court, or to prepare reports for your attorney or the Court, you will be charged \$175.00 per hour for these special services. These services will not be billed to insurance as they are not mental health therapy/evaluation services. You will not necessarily be reminded of these special charges.

I understand that charges will be added to my account for professional services rendered by my therapist (i.e., phone contacts over 5 minutes, preparation of special forms, reports, court time, etc.). The fee for these services is \$130.00/hour and is not covered by insurance. The client will be reminded prior to the delivery of these services of the additional charges. For court-ordered Custody Evaluations the fee is \$130.00 per hour for all services. I understand that copies of my records will be charged to myself and not to my insurance company for a fee of \$175.00 or \$10.00 per page whichever is greater.

This office does not perform disability examinations at this time.

The following applies to all clients.

I am aware that I will be charged \$45.00 for each appointment that I miss or cancel less than 48 hours in advance or I may be discharged from SCMH LLC if I should no show more than 2 times in a 6 months period. I am also aware that copays must be paid at the time of service. Failure to do so will result in a \$5.00 charge in addition to the copay. I agree to pay this amount and I understand that these charges cannot be billed to my health insurance carrier. If I request a copy of my records I will be charged the rates listed in the Office Policies document I received.

In the case of default on payment of your account, collection costs and reasonable fees incurred by Sandia Crest Mental Health LLC in attempting to collect payment on your account will be charged to you. This will add 30% to your amount due.

I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable I will not be charged for the canceled session.

Signature _____ Date _____

Print Name _____

Legal Guardian _____ Date _____

Print Name _____



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Consent for Primary Care Physician Notification Release of Information

***Please Note: If you do not want us to notify your primary care physician, please sign and date and do not fill out this form.**

_____ No, I do not want to notify my primary care physician regarding my treatment.

I understand there could be serious interaction between medications that all my providers prescribe and choosing not to inform my Primary Care Provider is a serious and possibly life threatening risk.

Signed _____ Date: _____

_____ Yes, I would like you to notify my primary care physician regarding my treatment.

Please complete remainder of this form

I, _____ hereby authorize Sandia Crest Mental Health LLC to disclose to my Primary Care Physician, all clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of my health issues.

Primary Care Physician Name: _____

Primary Care Physician Practice Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Telephone: () _____

This authorization becomes effective as of today's date and may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. Unless earlier revoked by me, this authorization automatically terminates one year from today. I understand that this authorization does not extend to the release of any AIDS/HIV information unless I also placed my initials here: _____. I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I (or my legal representative) am entitled to a copy of this authorization form for my records.

X	X	X
Legal Signature of Client	Printed Name of Client	Date

X	X	X
Legal Guardian Signature	Guardian Printed Name	Date

Notice to Recipient: This information has been disclosed to you from records protected by Federal Confidentiality Rules and/or state law. In accordance with Federal and State Law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug clients.



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Date: _____

PCP Name: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Dear Provider: _____

Your Patient _____ has identified you as their primary care provider. In my work with this client, we have discussed the importance of coordinating an individual's total health care across health care professionals. In response to this discussion, the above named client has given his/her consent for me to contact you, introduce myself as his/her behavioral health care practitioner and work directly with you when necessary.

The above-mentioned client began behavioral health care with me on, _____.. As the client's overall health care is of primary importance, I will be available to you and can be reached at (505) 463-2072. I look forward to our working together on an integrated approach for an optimal treatment outcome.

If applicable, this is also to notify you the following medication prescribed for our mutually shared patient:

Medication: _____ Dosage: _____ Sig: _____

Medication: _____ Dosage: _____ Sig: _____

Medication: _____ Dosage: _____ Sig: _____

Respectfully,

X

Edward Lobaugh, MSN, APRN BC, CNP, CNS

Family Psychiatric Mental Health Nurse Practitioner



Sandia Crest Mental Health^{LLC}

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RELEASE OF INFORMATION CONSENT FORM

I, _____, authorize Edward Lobaugh CNP of Sandia Crest Mental Health

to _____ (send) _____ (receive) the following _____ (to) _____ (from) the following agencies or people:

Name: _____ Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

And/or

Name: _____ Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

And/or

Name: _____ Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

To share:

- Academic Testing Results Psychological Testing Results Behavior Programs
- Case Notes Service Plans Intelligence Testing Results
- Summary Reports Medical Reports Vocational Testing Results
- Personality Profiles Progress Notes Psychological Reports
- Lab results Prescriptions hx Entire Record
- Other _____

The above information will be used for the following purposes:

- Planning Appropriate Treatment or Program Continuing Appropriate Treatment or Program
- Determining Eligibility for Benefits or Program Case Review
- Updating Files Providing continuity of care

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client _____ Date: _____

Parent or Legal Guardian _____ Date: _____

Signature of Witness if client is unable to sign: _____ Date: _____

Signature of Person informing client of right _____ Date: _____