THE CENTER FOR AUTISM
a PHMC affiliate

4601 Market Street
Philadelphia, PA 19139

215.878.3400 PHONE
215.878.2082 FAX
THECENTERFORAUTISM.ORG

Client Name: _____ *Date:* _____

CONSENT FOR ELECTRONIC COMMUNICATION

The Center for Autism hereby informs _____ (client/parent/legal guardian) that unencrypted email and text messaging are not secure forms of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email or text message may be misdirected, disclosed to, or intercepted by, unauthorized third parties. However, you may consent to receive email and/or text messages from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication, such as first names only.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
My email address is: _____

☐ I consent and accept the risk in receiving information via text message. I understand I can withdraw my consent at any time.
My cell phone number to send texts to is: _____

☐ I do not consent to receiving any information via email or text message. I understand that I can change my mind and provide consent later.

I understand that this consent is effective as of the date signed, will remain **valid for one year** from the date of signature, and may be revoked by the parent/legal guardian at any time during this timeframe.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ **(Check if applicable) The Client is physically unable to provide a signature and has instead freely given verbal consent as authorized above, fully understanding the nature of this form.**

_____ _____
Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

Two witness signatures are required when the Client is physically unable to sign and has given verbal consent.

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PHMC Telehealth Consent and Acknowledgment

PHMC Telehealth is sponsored by Public Health Management Corporation and its subsidiaries (collectively referenced herein as "PHMC") and is a telehealth service used by PHMC practitioners for use by PHMC patients and their providers. This PHMC Telehealth Consent and Acknowledgement ("Consent and Acknowledgment") describes your rights and responsibilities with respect to accessing and receiving healthcare services via telehealth technologies. Each of *PHMC Privacy Policy* and the *PHMC HIPAA Notice of Privacy Practices* apply to PHMC telehealth users. Use of PHMC Telehealth visit is subject to this Consent and Acknowledgement. By entering into the PHMC Telehealth visit with your provider, you agree that you have provided your consent. You hereby certify that you are the client, patient or patient's parent/legal guardian (hereafter called "patient") and can provide valid consent for yourself, that you agree to the terms of this Consent and Acknowledgement, and that you have received and reviewed the *PHMC HIPAA Notice of Privacy*. You also have the right to receive a paper copy (if a paper copy has not already been provided to you) of the *PHMC HIPAA Notice of Privacy* by contacting the PHMC Privacy Officer at 215-985-6242 or by mail at Public Health Management Corporation, Attention: Privacy Officer, 1500 Market Street, LM15, Philadelphia, PA 19102.

- PHMC Telehealth should never be used for emergencies. Please call 911 or visit your local emergency services provider in an emergency situation.

I acknowledge and agree to the following:

1. PHMC Telehealth is a telemedicine service that connects PHMC providers with PMHC patients for visits via interactive, live-streaming audio and/or video. PHMC Telehealth is offered to PHMC patients so that they may obtain services at convenient locations and to allow the patient and provider to exchange health and other information confidentially through electronic means. The patient's provider will decide if a video visit is appropriate for the patient and will discuss the proposed care, treatment and specific services offered through video with you.

2. In a PHMC Telehealth visit, the provider is located at one location (distant site) and the patient is located in another location (originating site), and the two sites may be located in different states and be subject to different state laws that may impact, for instance, your provider's ability to prescribe certain medications.

3. PHMC or the provider must collect certain information from you. For example, the provider may ask you for personal and medical information, such as patient name to verify identity or insurance information, information on the patient's current condition or medical history, consent to a specific treatment, and/or confirmation of the patient's address, including state. Any information that you provide to the provider or PHMC related to the visit must be truthful, accurate, complete and updated health information, or the quality and effectiveness of the services provided may be affected.

4. The decision to participate in a PHMC Telehealth visit is voluntary, and you can end the use of PHMC Telehealth at any time. PHMC and the provider may also end a video visit or your use of PHMC Telehealth for any reason including, but not limited to, the provider's decision that the patient should be seen in person; your or the patient's unwillingness or inability to properly use PHMC Telehealth; or concerns about the equipment.

5. The PHMC provider conducts the PHMC Telehealth visit as he or she decides is appropriate and determines the diagnosis and treatment.

6. The PHMC provider may request assistance from facility staff, a caregiver or you (if you are the parent/guardian) at the patient's location to facilitate the services, or may request that you (if you are the parent/guardian) not be present for the video visit. Because the provider may be located at a PHMC facility, there may be other PHMC personnel, such as case workers or nurses as well as other required PHMC professionals, who are present at or able to view the visit without your knowledge.

7. You are solely responsible for any sharing of information that you intentionally or unintentionally communicate to non-PHMC people during your video visit. Therefore, use of PHMC Telehealth may not be appropriate if there is sensitive information that you would only wish to discuss directly with you as the patient or if you are the parent/legal guardian for your child or your/your child's provider.

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8. YOU UNDERSTAND THAT THE PHMC TERMS AND CONDITIONS OF USE, THE PHMC PRIVACY POLICY AND THE PHMC HIPAA NOTICE OF PRIVACY PRACTICES APPLY TO YOUR USE OF PHMC TELEHEALTH INCLUDING BUT NOT LIMITED TO ALL TERMS REGARDING SECURITY, NO WARRANTIES, AND LIMITATIONS OF LIABILITY. YOU ACKNOWLEDGE THAT YOU HAVE CAREFULLY REVIEWED AND AGREE TO THE TERMS AND CONDITIONS OF USE, PHMC PRIVACY POLICY AND PHMC HIPAA NOTICE OF PRIVACY PRACTICES PRIOR TO ANY USE OF PHMC TELEHEALTH. IF YOU DO NOT AGREE TO TERMS IN THESE POLICIES, YOU SHOULD NOT USE THE PHMC TELEHEALTH.

9. You agree to follow the instructions for the use of the PHMC Telehealth. Other than information received directly by the PHMC provider or other care provider, no information provided on or through PHMC Telehealth shall be treated as medical or clinical advice.

10. The audio and images transmitted during a PHMC Telehealth visit may be stored by PHMC in the patient's medical record and used, maintained, shared and secured like any other protected health information ("PHI") under HIPAA. In general, PHMC may use or disclose any PHI obtained during a PHMC Telehealth visit without your consent for treatment (including with non-PHMC treating providers), payment, internal operations and other purposes, such as required by law. Please see PHMC's Notice of Privacy Practices for more information on how PHMC protects PHI.

11. PHMC complies with the law and best industry practices to provide for the security of a PHMC Telehealth visit. However, no system can perfectly guard against risks such as a breach caused by an intentional intrusion, inadvertent disclosure of information, or the failures or limitations of equipment used to transmit relevant data that could cause delays in or the inability to provide evaluation or treatment.

12. If you have any questions about PHMC Telehealth or this Consent and Acknowledgement, please contact the PHMC Compliance Director at 215-985-2538. By accepting the PHMC Telehealth Consent and Acknowledgement terms, you agree that you have had any questions answered before initiating a PHMC Telehealth Visit. PHMC recognizes that you may have more questions at the time of a telephone or video visit, and you will be able to have these questions answered at that time.

13. This Consent and Acknowledgment applies to each telephone or video visit through PHMC Telehealth. You will be asked to provide a separate consent as required under law and PHMC policy, such as for a medical procedure.

14. If you are agreeing to the terms of this Consent and Acknowledgment on behalf of the patient, you have appropriate legal authority as a parent or legal guardian. The PHMC Telehealth website is not directed at children under 13 (even if the patient is under 13). This means that if you are the parent or legal guardian acting on behalf of the patient who is under 13, you are considered to be the exclusive user of PHMC Telehealth, and any and all information provided on PHMC Telehealth on behalf of the patient is provided solely by you.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

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Client Name: _____ *Date:* _____

CLIENT CONSENT TO TREATMENT FORM

I do hereby consent to being treated by The Center for Autism. I understand that the services provided by The Center for Autism Are Outpatient Mental Health Services. I understand that the service(s) _____ (Client's Name) will receive is (are) OUTPATIENT SERVICES/IBHS.
The proposed intervention(s), treatment(s) and/or medication(s) have been explained to me along with any potential benefits, risks and side effects. I understand that I have the right to refuse treatment interventions, including medications.

I hereby give my consent The Center for Autism to invoice my Medical Assistance or the assigned Behavioral Health Managed Care Organization for eligible services provided to _____ (Client's Name). Furthermore, I assign benefits/payments to The Center for Autism involving any private Insurance Plan(s) in effect at the time of services rendered.

I further hereby express my understanding there are instances in which my consent is not needed to release relevant treatment information. Those who do not need to ask consumer's permission are: people involved in the individual's mental health treatment or to whom the individual is referred for treatment, people providing emergency medical care, an attorney representing the individual at a commitment hearing, a court, people conducting program or utilization reviews or third party payers (those who pay for the treatment). These people may only see as much information as they need for the specific purpose requested.
Please identify which program this consent to treatment authorization is representing:

☐ Intake/Assessment & Evaluation/Outpatient

Please check the following that apply:
☐ I give consent for messages to be left:
- ☐ On my answering machine at home
- ☐ To someone who answers the phone at my home
- ☐ On my answering machine at work
- ☐ To someone who answers the phone at my place of employment

☐ I do not give consent for messages to be left at my home or work

I understand that this consent to treatment is effective as of the date signed, will remain **valid for one year** from the date of signature, and may be revoked by the parent/legal guardian at any time during this timeframe.

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Client Name: _____ *Date:* _____

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ **(Check if applicable) The Client is physically unable to provide a signature, and has instead freely given verbal consent as authorized above, fully understanding the nature of this form.**

_____ _____
Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

Two witness signatures are required when the Client is physically unable to sign and has given verbal consent.

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Client Name: _____ *Date:* _____

CONSENT TO PHOTOGRAPH AND VIDEO/AUTHORIZATION FOR RELEASE OF PHOTOGRAPH/VIDEO DISCLOSURE

I hereby authorize the Center for Autism to create and use or release photographs, video, audio or other images (collectively, "Photographs") of _____, date of birth _____, for the purposes of (check all that apply):

☐ **Yes** ☐ **No Teaching and Education:** Photographs may be used for internal and external training, education, and supervision purposes, as well as educational and professional purposes (such as presentations at professional conferences) involving external audiences.

☐ **Yes** ☐ **No** **Documenting Milestones**: Photographs may be released to families of other clients for the purpose of sharing memories.

☐ **Yes** ☐ **No Public Relations**: Photographs may be used for public relations & marketing (brochures, website, newsletters, videos) or in connection with news media stories or coverage relating to The Center for Autism or its programs.

I understand that other than as authorized herein, The Center for Autism will not disclose additional personally identifiable information in conjunction with the use of any Photographs (including, but not limited to, the individual's name, age, date of birth, social security number, address information, or treatment information) for purposes unrelated to treatment, payment or health care operations, without prior express permission, unless otherwise required or permitted by law. I understand that once disclosed pursuant to this authorization, Photographs may be subject to re-disclosure by the recipient such that they are no longer protected by law.

I understand that Photographs may be used for treatment purposes and medical documentation and may be included the individual's medical records. The individual may be videotaped at any time while in the building for medical and/or security purposes.

I understand that this authorization is effective as of the date below and will remain **valid until <u>one year from the date of signature</u>**, or until otherwise revoked. I understand that I may revoke this authorization at any time by written or oral request except to the event that action has been taken in reliance thereon. I have also been informed of my right, subject to Pennsylvania Mental Health Records Confidentiality regulations at 55 Pa. Code 5100.31-39, to inspect the information to be released.

I understand that all reproduction rights and copyrights associated with any Photographs authorized herein are and will remain the property of The Center for Autism, its successors and/or assigns, and I waive any right to compensation arising from or related to the use of the Photographs. I agree to release and hold harmless the Center for Autism and its officers, agents and employees from and against any claims, damages or liability arising from or related to the use of Photographs as authorized herein.

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Client Name: _____ *Date:* _____

I certify that this form has been explained to me and that I have read and understand its contents. I further certify that I fully understand the meaning and impact of this release. I understand that this authorization is voluntary, and that The Center for Autism will not condition treatment upon its execution.

I certify that I have been informed (as per the Center for Autism's Risk Management, Video Monitoring, & Clinical Observation Policies) that all of the Center for Autism's program rooms, hallways, and lobby areas are videotaped for risk and liability purposes.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ **(Check if applicable) The Client is physically unable to provide a signature and has instead freely given verbal consent as authorized above, fully understanding the nature of this form.**

_____ _____
Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

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Client Name: _____ *Date:* _____

CONSENT TO RELEASE/VERBALLY SHARE INFORMATION WITH PRIMARY CARE PHYSICIAN

I, (We) _____ Parent or Guardian of _____ born on _____ (DOB), hereby authorize The Center for Autism and _____ (Primary Care Physician's Name) to share or release information (medical and mental health records) pertaining to my son/daughter. The information that may be shared is limited to treatment planning. These records are for the purpose of providing continuity of care across all environments.

Address: _____
City: _____State: _____ZIP: _____
Phone Number: _____

I understand that my authorization is effective on the date of my signature and is **valid for one year** or until otherwise revoked.

I have been informed that I may revoke this authorization by written or oral request except to the extent that action has been taken in reliance thereon. I have also been informed of my right, subject to Section 5100.31-39 of the Mental Health Procedures Act of 1976, to inspect the information released.

I certify that this form has been fully explained to me and that I understand its contents. I further certify that I fully understand the implications of releasing these confidential records.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ **(Check if applicable) The Client is physically unable to provide a signature, and has instead freely given verbal consent as authorized above, fully understanding the nature of this form.** *

_____ _____
Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

**Two witness signatures are required when the Client is physically unable to sign and has given verbal consent.*

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Client Name: _____ *Date:* _____

CLIENT INFORMED CONSENT FOR CONTRACTED INSURANCE PROVIDERS AND BEHAVIORAL HEALTH PRACTITIONERS – POLICY # 600.02

Policy: It is the policy of The Center for Autism (CFA) to require the appropriate, confidential and timely exchange of information between insurance providers in order to achieve the safest and most effective coordination of care.

Purpose: The purpose of this policy/document is for the exchange of information across all levels of behavioral healthcare and between all behavioral healthcare provider types including primary care physicians (PCPs).

1. Exchange of information requirements across all levels of behavioral health care and between all behavioral health care provider types:

From	To	Conditions that Require Exchange	Minimum Information to be Exchanged
CFA, Commercial Insurance providers, Behavioral Health Managed Care Insurance Providers both Medicaid and Non Medicaid).	CFA, Commercial Insurance providers, Behavioral Health Managed Care Insurance Providers both Medicaid and Non Medicaid.	When authorization is needed for treatment, payment information, and any treatment information to sustain compliance with The Centers for Medicaid and Medicare.	Determination of Medical Necessity, billing statements/details/financial information, and any treatment records required to support billing compliance. Specific coordination of care issues identified through CFA and/or the insurance provider/s.
The Center for Autism (CFA)	Other behavioral health practitioner/s	When making or receiving a referral or when the member is in treatment with another behavioral health practitioner.	**1.** Diagnosis Medication/s Prescribed *(Psychiatrists and other prescribing practitioners only)* **2.** Any significant risk status or issues **3.** Severity of problem **4.** Frequency of treatment **5.** Treatment recommendations/plan **6.** Significant coordination of care issues
Testing psychologist and Psychiatrists	The Center For Autism (CFA)	When receiving a referral for psychological and/or psychiatric testing. When receiving a psychological and/or psychiatric medical	Summary report on test results and treatment recommendations to and from referring practitioner.

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		recommendation for treatment.	

2. Enrollee Consent and Confidentiality

In accordance with the Health Insurance Portability and Accountability Act of 1996, all member identifiable information involved in exchange of information is confidential.

The Center for Autism requires that the behavioral health provider procures a written and signed release of information and authorization to obtain prior to exchanging the information required by this policy. However, there are instances in which consent is not needed to release relevant treatment information. Those who do not need to request a Client's/member's permission are: professionals involved in the individual's mental health treatment or to whom the individual is referred for treatment, professionals providing emergency medical care, an attorney representing the individual at a commitment hearing, a court, insurance or clinical professionals conducting program or utilization reviews and compliance audits, third party payers, commercial payers, and Managed care Organizational payers (those who render payment for the treatment).

If a member refuses to release information for coordination of care, this should be documented in the member's treatment record. The provider should weigh the risks of failure to communicate even without the enrollee consent, especially in those instances when the enrollee is an adverse threat, or when the enrollee is on medication that could potentially be harmful if combined with other medication. This documentation will be seen as fulfilling the practitioner or provider's requirement to facilitate the required exchange of information and the case will be considered as "not applicable" toward any monitoring denominators.

3. I understand that protected health information includes any information created or received by The Center for Autism in any form, that identifies an individual and is related to the past, present, or future. This information is specific to:

1. **Physical or mental health of the individual**
2. **Provision of health care to the individual**
3. **Payment for health provided to the individual**

I hereby give my consent for The Center for Autism to invoice my Medical Assistance, Commercial Insurance Carrier, or the assigned Behavioral Health Managed Care Organization for eligible services provided to _____ (Client's Name).

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

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_____ _____
Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

**Two witness signatures are required when the Client is physically unable to sign and has given verbal consent.*

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Client Name: _____ *Date:* _____

NO SHOW AND CANCELLATION POLICY

As a client of The Center For Autism (CFA), it is your responsibility to keep scheduled appointments. If you are unable to keep your appointment, please call the CFA at (215) 220-2126 to reschedule. Any client who does not arrive for their appointment or does not call in advance will be considered a "no show." If you arrive late to an appointment, you may be provided with the remaining time designated for the appointment and may need to be scheduled for an additional appointment to complete the appointment. Clients that arrive more than 15 minutes late will be rescheduled to a different date and time. We recommend being 15 minutes early for your appointment in order to complete necessary paperwork. Clients and families that have 2 consecutive no-show statuses for a scheduled appointment will be referred to an outside agency. Clients and families that have 3 consecutive re-scheduled statuses for appointments (initial appointments) will be referred to an outside agency. This excludes re-scheduling due to urgent & emergent situations.

I, _____, understand the no show and cancelation policy.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ **(Check if applicable) The Client is physically unable to provide a signature, and has instead freely given verbal consent as authorized above, fully understanding the nature of this form.** *

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Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

**Two witness signatures are required when the Client is physically unable to sign and has given verbal consent.*

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Client Name: _____ *Date:* _____

Client's Rights

Services provided by the Center for Autism are Outpatient Mental Health Services/Intensive Behavioral Health Services (IBHS). It is the policy of the Center for Autism to afford people receiving Mental Health Services in Pennsylvania the following rights:

- *The right to be treated with dignity and respect.*
- *The right to choose services or programs in which to participate based upon information about rules, treatment procedures, costs, risks, rights and responsibilities.*
- *The right to ask questions and get answers about services.*
- *The right to participate fully in all decisions about treatment or services.*
- *The right to request changes in treatment or services.*
- *The right to receive treatment in the least restrictive setting – one that provides the most freedom appropriate to individual treatment needs.*
- *The right to refuse treatment or services unless ordered by the Court to participate.*
- *The right to be informed about rules that will result in discharge from a program if violated.*
- *The right to participate fully in decisions regarding discharge from a program and to receive advance notice regarding the proposed discharge, unless individual behavior threatens the well being of another person.*
- *The right to know the name of medications prescribed why they have been prescribed and what possible side effects might be.*
- *The right to refuse to take medication (this should not be done suddenly without first being discussed with the psychiatrist to assess possible dangers.)*
- *The right to have one's family involved in treatment.*
- *The right to refuse one's family's participation in treatment.*
- *The right not to be subjected to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.*
- *The rights to make complaints, have them heard, get a prompt response, and not receive any threats or mistreatment as a result.*
- *The right to file a grievance if not satisfied with the response to a complaint.*
- *The right to be assisted by an advocate of one's choice, for example, family, friend, case manager, member of a consumer advocacy committee or organization, etc.*
- *The right to review one's records with two exceptions. Limited portions of consumer records can be withheld from the consumer if the treatment team leader has written that seeing specific information would a) be harmful to the individual's treatment, or b) reveal the identity or break the trust of someone who has provided information in confidence.*
- *The right to decide whom else can see one's records, with several exceptions. Those who do not need to ask consumer's permission are people involved in the individual's mental health treatment or to whom the individual is referred for treatment, people providing emergency medical care, an attorney representing the individual at a commitment hearing, a court, people conducting program or utilization reviews, or third party payers (those who pay for the treatment.) These people may only see as much information as they need for the specific purpose requested.*
- *The right to exercise all civil and legal rights afforded to citizens of the United States; for example, vote, marry, obtain a driver's license, write a will, etc.*

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- *The right not to be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.*

It is the policy of the Center for Autism to provide Clients with a Client Rights Form which advises them of their rights and responsibilities, provides instructions for filing a complaint and identifies consumer advocacy organizations. People receiving Inpatient or Residential Mental Health Services have additional rights. We would be happy to discuss those rights with you if you wish.

People receiving Mental Health Services in Philadelphia have the following responsibilities:

1. To participate, as fully as able, in one's treatment. Strive toward:
    - Taking an active part in the development of the individual treatment plan.
    - Telling staff what one needs and wants from services.
    - Sharing information with staff that is relevant to one's service
2. To respect the rights of other consumers and staff.
3. To respect the rules established by the agency where one receives services; speak out if the rules seem unreasonable.
4. To give staff the opportunity to resolve the problems.

MAKING A COMPLAINT

Can anyone make a complaint? Yes. Anyone who has witnessed, or has knowledge of, a violation of a consumer's rights can bring the matter to the agency's attention.

Client's Rights

What will happen if I make a complaint? People will ask you to give details about what happened, when it happened, where it took place, and who was involved. You should not be threatened, punished or forced to leave a program just because you make a complaint. Philadelphia community mental health programs are not permitted to mistreat consumers or terminate services because someone speaks up about a problem

What the agency will do about the situation depends on what the problem is, but they are required to let you know promptly what they will do to address the situation and try to prevent it from happening again.

Who can help me make a complaint? You may ask a family member, friend, advocate, case manager, or anyone else you choose to help you. If you feel you need the assistance of an advocate, there may be a Consumer Advocate or advocacy group at your agency or you may choose from the list of advocacy groups attached to your copy of this document.

How do I make a complaint? If you feel comfortable, tell the person you think has treated you unfairly that you have a complaint. Explain to him or her you think was wrong and what you want to change. If you feel you cannot discuss the issue with this person, or if you feel that the situation has not been resolved, you should notify the Director of your treatment program, who will attempt to resolve the problem. The Program Director will document your concern, and the proposed solution in writing within 48 hours; you will be given an opportunity to comment in writing, including expressing your

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satisfaction with the process and/or the result. If you are not satisfied with the result, the Director of Quality & Compliance will initiate the agency's grievance procedure. The Director of Quality & Compliance will schedule a meeting for you with two individuals within the agency who are authorized to make decisions and at least one of who is removed enough from the situation to provide an uninvolved viewpoint (for example, the Social Worker and the Human Resources Director or Senior Psychiatrist and the Clinical Director.) The individuals selected for this grievance will vary and will be based on the specific nature of the complaint. The Chief Executive Officer will not be part of the initial grievance team. The goal of this meeting will be to reach a mutual understanding. The meeting and its results will be documented within48 hours; you will be given an opportunity to comment in writing, including expressing your satisfaction with the process and/or the result. If you are not satisfied with the results of this meeting, the Center's Chief Executive Officer will convene a meeting with you and the grievance team with whom you met. The Chief Executive Officer will: **1)** allow all parties to express their position, **2)** will offer alternatives and allow them to be discussed, and **3)** will make a decision. This decision will be the Center's final position. The meeting and its results will be documented within 48 hours; you will be given an opportunity to comment in writing, including expressing your satisfaction with the process and/or result. You will be given copies of all documentation of the grievance procedure.

The Center for Autism
Clinical Director
4601 Market Street
Philadelphia, PA 19139
215-878-3400

PHMC Total Quality Management
Managing Director of TQM
1500 Market Street Suite 1500
Philadelphia, PA
215-985-6242

What happens if I cannot resolve my problem within the agency? If you feel that your complaint has not been satisfactorily addressed by the Center, and you feel the situation will not improve without outside intervention, please contact your provider first and then the City of Philadelphia Department of Behavioral Health and Intellectual Disability Services at the following address:

For CBH Members:

ATTN: Provider Network Operations
Community Behavioral Health (CBH)
801 Market Street., 7th Floor
Philadelphia, PA 19107
Phone Number: 888-545-2600

Manager, Quality Improvement

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City of Philadelphia
Department of Behavioral Health and Intellectual Disability Services
Division of Mental Health Services
1101 Market Street, 7th Floor
Philadelphia, PA 19107-2907

The Department of Behavioral Health and Intellectual Disability Services (DBHIDS) staff will investigate by asking questions of the people involved and everyone else who has knowledge of the situation and will try to resolve the problem. Someone from DBHIDS will respond to your complaint within seven days.

OR

Pennsylvania Department of Public Welfare
Room 105, Building #57
Norristown State Hospital
1001 Sterigere Street
Norristown, PA 19401

What happens if the OMH/DBHIDS or the Department of Public Welfare cannot help me resolve my problem? If you are not satisfied with the OMH/DBHIDS response, you can appeal to the MH Human Rights Committee. The Human Rights Committee is a group of citizens appointed by the MH Advisory Board to protect the rights of people receiving mental health services. The majority of committee members are consumers of mental health services.

How do I appeal to the Human Rights Committee? You can appeal to the Human Rights Committee by sending your complaint and documentation to the Chairperson of the Human Rights Committee. The address is:

Human Rights Committee Chairperson
C/O Philadelphia DBHIDS
Division of Mental Health Services
1101 Market Street, 7th Floor
Philadelphia, PA 19107

What happens when I file an appeal? The Human Rights Committee will investigate by asking questions of everyone involved in the complaint, as well as anyone else who has additional information about the situation. You will be invited to meet with the Committee within 30 days. You may ask a family member, a friend, an advocate, or anyone else you choose to accompany you and speak on your behalf. The person or people you are accusing of violating your rights may also be invited to attend the meeting.

The Committee will make a decision following the meeting. The findings and recommendations of the Human Rights Committee will be sent in writing to the Deputy Health Commissioner for Mental Health/Mental Retardation, who is the highest authority in the Philadelphia community mental health system, within three working days. A copy of the committee's findings and recommendations will also be sent to you and to the person or people accused of violating your rights.

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What action will be taken? Within 30 days, the Deputy Commissioner for the Department of Behavioral Health and Intellectual Disability Services will send the Human Rights Committee a written report stating what actions have been taken in response to the committee's recommendations. Copies of this report will also be sent to you and all other individuals involved in the complaint.

I have read this form, or it has been read to me. I have been given an opportunity to ask questions and those questions have been answered.

My signature on this document indicates that I have been given a copy of the Client's Rights Form, a list of advocacy organizations and that I understand the contents of this document.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ **(Check if applicable) The Client is physically unable to provide a signature and has instead freely given verbal consent as authorized above, fully understanding the nature of this form.** *

_____ _____
Signature of Staff Person or Witness Date

_____ _____
Signature of Staff Person or Witness Date

**Two witness signatures are required when the Client is physically unable to sign and has given verbal consent.*

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ADVOCACY ORGANIZATIONS

Mental Health Partnerships Philadelphia SHARE is run by and for mental health consumers. It provides both individual and systems advocacy. It operates self-help and consumer advocacy groups in Central, West and Northeast Philadelphia. Staff can assist with problems involving mental health services, housing, government benefits, and legal matters. 833 Chestnut Street Suite 1100 Philadelphia, PA 19107 215-751-1800 800-688-4226 x216	**National Alliance for Mentally Ill (NAMI)** The Alliance for Mental Ill (AIM) is an advocacy group organized to give support to the families of consumers of mental health services, and to assist families in obtaining better treatment for relatives with mental illness. NAMI is closely associated with DBHIDS, Mental Health Association, Family Resources Network, Family Inclusion and Community Integrated Services NAMI Philadelphia 520 Delaware Ave Philadelphia, PA 19123 267-687-4381	**Consumer Satisfaction Team** CST is staffed entirely by individuals and family members of individuals who have received behavioral health services. CST strives to ensure desires and needs are relayed to DBHIDS and through publicly supported and funded services. 520 N. Delaware Avenue 7th Floor Philadelphia PA 19123 215-923-9627
Education Law Center The Education Law Center-PA is a non-profit law firm dedicated to ensuring that all of Pennsylvania's children have access to quality public education. 1800 JFK Blvd., Suite 1900-A Philadelphia, PA 19103 215-238-6970	**Pennsylvania Mental Health Consumers' Association (PMHCA)** PMHCA is a network of self-help groups and consumer-run alternatives dedicated to restoring respect, human rights, and dignity to mental health consumers in PA 4105 Derry Street Harrisburg, PA 17111 1-800-887-6422 717-564-4930 PMHCA@pmhca.org	**Disability Rights Network** Protects and advocates for individuals with disabilities and their families to ensure they live the lives they choose, free from abuse, neglect, discrimination and segregation. 1800 JFK Boulevard, Suite 900 Philadelphia, PA 19103 215-238-8070
Parents Involved Network (PIN) PIN is an organization that assists parents or caregivers of children and adolescents with emotional and behavioral needs. PIN provides information, resources, support services and advocacy. PIN can also provide information regarding Behavioral Rehabilitative Services. 1211 Chestnut Street Philadelphia PA, 19107 267-507-3860	**Autism Society of America (ASA) Greater Philadelphia Chapter** ASA is a non-profit, all volunteer parent-directed association dedicated to the general welfare of all individuals with autism, pervasive developmental disorders and other profound disorders of communication and behavior. P.O. Box 60159 King of Prussia, Pa 19406-0159 Phone: 610-358-5256	**Hispanos Unidos Para Ninos Excepcionals (HUNE)** HUNE provides advocacy and support for Latino families that have children with disabilities. 2200 N. 2nd Street Philadelphia, PA 19133 Phone Number: 215-425-6203 www.huneinc.org

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ASCEND ASCEND – www.ascendgroup.org OR infor@ascendgroup.org ASCEND provides support, information, resources, and advocacy for Asperser's Syndrome (NOTE: there is a $35 fee to access their resources data base). ASCEND families and individuals hold many meet up groups throughout the year. You can sign up them at this website: http://www.meetup.com/autism-414/	**SEAMAACC: Southeast Asian Mutual Assistant Associations Coalition -** www.seamaac.org 1711 South Broad Street 215-467-0690 SEAMACC is a multi-service center offering social supports and activities for Asian families.	**Drop-In Centers** Drop-In Centers provide consumers with peer support, referrals to mental health services, individual advocacy, and advocacy to improve the mental health system. A drop-in center is a safe haven for adults, an accepting place for anyone in need of support, advocacy and self-empowerment on their recovery journey. **Northeast Philadelphia Consumer Center** Provides central location for self-help and mutual support, information, and resource sharing, as well as opportunities to socialize. Everyone in the center - staff included - has had some experience with mental illness and the mental health system can share their experience with other consumers. 6801 Frankford Avenue Philadelphia, PA 19135 215-624-6163 **A New Life Care (Resource Learning Center)** Recovery Learning Centers connect participants to natural community supports along with offering a warm and welcoming place to come to engage in the service system. Offering unique facility-based options, the Centers are actively engaged in connecting people to resources and services in community environments. In all instances, the focus of these services will be driven by the service participant with an aim toward community integration and the use of existing community resources. 3119 Spring Garden Street Philadelphia, PA 19104 215-243-0550

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PUBLIC HEALTH MANAGEMENT CORPORATION NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

We at Public Health Management Corporation are required by law to maintain the privacy of your protected health information and to provide you with this Notice describing our privacy practices. Protecting the privacy and confidentiality of information about our participants is very important to Public Health Management Corporation. Accordingly, we strive to comply with each of the following practices in everything we do.

Protected Health Information ("PHI") means individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that is created or received by PHMC and that relates to the past, present, or future physical or mental health condition of a individual; the provision of health care services to an individual; or the past, present, or future payment for the provision of health care services to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

AUTHORIZED USES AND DISCLOSURES: Your consent or authorization is required for us to use or disclose your Protected Health Information (PHI):
For your Treatment: With your consent, we may use and disclose your PHI in order to ensure that you receive proper and needed health care services. For example, we may disclose your health information, to another health care provider involved in your care, or to whom you are being referred for additional health related services.
Authorization is also needed by you to disclose your PHI for any of the following circumstances:
• Psychotherapy notes
• Research
• Fundraising and Marketing
• In any circumstance where we receive remuneration for the PHI
• Immunization information (does not have to be written, may be verbal)
• For disclosure to a third party such as an attorney or medical representative
• Other uses and disclosures not described in this notice

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:
We are permitted or required to use your health information for various purposes. The following categories describe different ways that we use and disclose PHI. However, uses or disclosures that we are permitted to make will generally fall within one of the following categories:
FOR PAYMENT: We may use and disclose your PHI so that we may obtain payment for the treatment and services we provided to you, from you, an insurance company, funding source or another third-party payer.

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For example, we may need to give your insurance company or another payer information about your diagnosis, treatment, or services we provided to you for PHMC to receive payment and/or funding for the treatment and/or services provided to you.

FOR PHMC'S INTERNAL OPERATIONS:
We may use and disclose your PHI for our internal operations. Operations is defined as those activities that are necessary to run our offices, maintain licensure, accreditation, obtain funding and to make sure that our participants receive quality care and/or services**.** For example, we may use your PHI to review our treatment of you and the services that we provided and/or coordinated for you to evaluate our performance in meeting your needs.

HEALTH INFORMATION ORGANIZATION NETWORKS (HIO)
We may use or disclose your PHI through a participation in a secure health information network, including "Health Exchange of Southeastern Pennsylvania, Inc. (HSX)" which makes it possible for PHMC to share your health information electronically through a secure connected network. PHMC may share or disclose your Health Information to HSX and other secure HIOs, including HIOs contracted with the Commonwealth of Pennsylvania, and even HIOs in other states. Other health care providers, including physicians, hospitals and other health care facilities, that are also connected to the same HIO network as PHMC can access your Health Information for treatment, payment and other authorized purposes, to the extent permitted by law.

You have the right to "opt-out" or decline to participate in having PHMC share your Health Information through networked HIOs.

If you choose to opt-out of data-sharing through HIOs, PHMC will no longer share your Health Information through an HIO network, however it will not prevent how your information otherwise is typically accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

BUSINESS ASSOCIATES:
Certain aspects and components of the services PHMC offers are provided through contracts with outside persons and/or organizations. Examples of these outside persons and /or organizations include other duly appointed providers of services. For example, it may be necessary for us to provide certain aspects of your PHI to one or more of these outside persons or organizations in order to coordinate appropriate treatment and/ or services for you.

AS REQUIRED BY LAW: We may use or disclose your PHI for any purpose required by law. For example, PHMC may be required by federal, state or local law to use or disclose your PHI to respond to a court order proper authorities for law enforcement purposes. Another example is child immunization records required by schools by State law.

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GOVERNMENT OVERSIGHT AGENCIES: We may use or disclose your PHI if authorized by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings. For example, the Department of Public Welfare that conducts audits of medical assistance payments for services provided.

FOR PREVENTION OF VIOLENCE:
We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect or domestic violence.

FOR PUBLIC HEALTH ACTIVITIES:
We may use or disclose certain PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations. We may also disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

TO AVERT A SERIOUS THREAT TO PUBLIC HEALTH OR SAFETY:
We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or that of the public or another person**.** Any disclosure however, would only be made to an agency
or person able to help prevent the threatened harm.

MILITARY PURPOSES: We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities**.**

WORKERS'COMPENSATION:
We may disclose your PHI, If you are injured at work, to workers' compensation agencies or similar programs that provide benefits for work related injuries or illness as required or permitted by law**.**

SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES:
We will, if required by law release your PHI to the Secretary of the Department of Health and Human Services for enforcement of the Health Insurance Portability and Accountability Act.

DISCLOSURE RESTRICTION:
We restrict disclosure of PHI if an individual has paid out of pocket for health care services.

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PUBLIC HEALTH MANAGEMENT CORPORATION PARTICIPANT ACKNOWLEDGEMENT AND CONSENT OF NOTICE OF PRIVACY PRACTICES

To provide healthcare services and supports to you, the client, it will be necessary for Public Health Management Corporation (herein "PHMC") to use and/or disclose your protected health information for purposes of treatment, payment, and internal administrative operations. Maintaining the confidentiality of that information is important to PHMC. PHMC's Notice of Privacy Practices describes in more detail the uses and disclosures of your protected health information (herein "PHI") that are necessary and PHMC's obligations to protect that information. You have the right to review the Notice before you sign this Acknowledgement and Consent. By signing this Acknowledgement and Consent, you are agreeing that **CFA** , a program of PHMC, the professional staff, administrative staff and other participants involved in your care, may use and disclose your PHI in connection with your care, treatment, payment, and internal administrative operations.

PHMC may change the Notice of Privacy Practices in the future. If PHMC changes the privacy practices, you may obtain a copy of the revised Notice by visiting the website at www.phmc.org or by requesting a copy in person or by sending a written request to:

Privacy Officer
Public Health Management Corporation
260 South Broad Street
Philadelphia, PA 19102

You have the right to request that PHMC restricts how your protected health information is used or disclosed for treatment, payment, or health care operations. PHMC is not required to agree to the restrictions you request, but if PHMC does agree to a requested restriction, PHMC is obliged by that restriction.
You have the right to revoke this consent at any time, in writing, except to the extent that PHMC has previously used or disclosed your protected health information in reliance on this Consent.

I hereby acknowledge that I have been offered/received a copy of the Public Health Management Corporation's notice of Privacy Practices. I consent to the uses and disclosure of my personal health information as outlined in the Notice Practices for treatment, payment, and internal administrative operations.

_____ _____
Signature of Client (14 years of age or older) Date

_____ _____ _____
Signature of Client's Parent/Legal Guardian Date Relationship to Client

_____ _____
Signature of Staff Person Obtaining Consent Date

☐ Participant/Legal Guardian refuses to sign. _____