Sheridan Health Services
COLLEGE OF NURSING
UNIVERSITY OF COLORADO

SHERIDAN HEALTH SERVICES
CONFIDENTIALITY & CONSENT FOR CARE

CLIENT NAME: _____ **DATE:** _____

Note to client: If there are any words or statements below that you do not understand or would like more information about, please let us know before signing this consent form.

Confidentiality

Your confidentiality regarding your mental health and/or alcohol and drug abuse records is legally protected. We may not say to a person outside Sheridan Health Services (SHS) that you receive care at SHS or disclose any information identifying you as a client, **unless**:

- You consent in writing (or your parent consents in writing if you are under 15 years of age) ; or
- Disclosure is ordered or allowed by a court order; or
- You commit or threaten to commit a crime either at the program or against any person who works for the program (if so, your confidentiality is not protected); or
- In our clinical judgment, you become harmful to yourself or others or you have a medical emergency (we may disclose select information about you in order to protect you or others); or
- We suspect child abuse and/or neglect. We are required by state law to report all suspected abuse and neglect to state and local authorities; or

Information about you may be used for program audit or evaluation purposes.

Therapeutic, Advanced Practice Psychiatric Nursing and Outpatient Substance services at SHS are affiliated with the University of Colorado College of Nursing. If you receive behavioral health care from a licensed provider, we may be required to report your name, address, and social security number to the Division of Behavioral Health of the Colorado Department of Human Services. Also, if you are Medicaid eligible, SHS will submit billings that will include your diagnosis(es) for any reimbursable therapeutic services. This information will be released in compliance with the federal regulations governing confidentiality of mental health and drug and alcohol abuse patient records.

Violation of Federal law and confidentiality regulations by a program is a crime (See 42 U.S.C. 290 ee-3, 290ff-3 Federal laws; 42 CFR, Part 2, and 45 CFR, Parts 142, 160, 162, 164 for Federal Regulations). Questions about this can be directed to SHS clinical behavioral health staff.

Consent for Behavioral Health, Advanced Practice Psychiatric Nursing and Outpatient Substance Treatment

I consent (or assent if I am a minor) to have SHS provide assessment and treatment for my behavioral, psychiatric, substance use, emotional, social, and/or educational problems. I understand that my behavioral health care is provided by a treatment team under the supervision of a licensed clinician. I understand that my psychiatric care is also under the supervision of a nurse practitioner. I understand that my assessment may include psychiatric and psychological questionnaires and evaluations (including emotional, behavioral, and intellectual evaluations).

By signing this consent form, I hereby authorize and give my voluntary consent to be involved in mental health and/or drug/alcohol treatment by SHS. I understand my rights to confidentiality and their limits. I willfully enter into this treatment and understand my responsibility in working toward my treatment goals. I have been offered a copy of this form.

Consent for Follow-Up Contact

I hereby give permission to the staff of SHS to contact me after my discharge from the SHS program in which I was treated. The purpose of this contact is to conduct follow-up surveys to gather information concerning the effectiveness of our treatment programs. All information will be considered confidential, and is protected by federal confidentiality regulations (42 CFR, Part 2). I understand that no names or client identifying information will be used in reports which may be sent to insurance companies, managed service organizations or governmental human services agencies.

_____ _____
Signature of Client Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

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AUTHORIZATION TO USE AND RELEASE CONFIDENTIAL HEALTH INFORMATION

Individual's Name_____ _____/_____/_____
Last name, First name, Middle Initial – please print Individual's Birth Date

Address_____ Phone ( ) _____

City, State, Zip Code_____

I, _____ _____
Individual's name or name of person authorizing release of information legal authority to sign for individual

give my permission to use and release my confidential health information between:
Please check the agencies that are authorized to use, receive and disclose your protected health information

- ☑ Sheridan Health Services/Sheridan School Based Health Services
- ☐ Mile High Behavioral Healthcare
- ☐ ARTS Innovative Recovery Clinic
- ☐ ARTS Medication Assisted Treatment Clinics
- ☐ ARTS OTC – Outpatient Therapeutic Community
- ☐ ARTS Parkside Clinic
- ☐ ARTS Potomac Street Center
- ☐ ARTS Residential Peer I
- ☐ ARTS Residential Haven
- ☐ Sheridan School District
- ☐ Mile High Youth Corps
- ☐ ARTS Specialized Outpatient Services
- ☐ ARTS Synergy Outpatient Services
- ☐ ARTS Synergy Residential Services
- ☐ ARTS Westside Center for Change

I understand that by giving my permission, I will receive better coordinated quality health care. The focus of my care is on the whole person, with an individualized care plan developed for me. Only the amount of information reasonably necessary to achieve the purpose of this authorization will be shared.

CONFIDENTIAL HEALTH INFORMATION THAT MAY BE SHARED

I understand that confidential health information that may be shared includes:

Yes	No	*(Please Initial)*	
___	☐	☐	___ My diagnosis (the name of my disease or problem) and any allergies
___	☐	☐	___ Results of my lab tests, x-rays, urine tests and any other tests
___	☐	☐	___ Past/current medications prescribed to me, including dosage
___	☐	☐	___ My contact information including name, phone, address, etc.
___	☐	☐	___ Information about me, including my gender, ethnic group, age, employment information, etc.

Information in my health record may also be shared about:

Yes	No	*(Please Initial)*	
___	☐	☐	___ My diagnostic evaluation
___	☐	☐	___ My treatment plan
___	☐	☐	___ My mental health status (not including psychotherapy notes)
___	☐	☐	___ Trauma history
___	☐	☐	___ My drug or alcohol use
___	☐	☐	___ HIV/AIDS status
___	☐	☐	___ Sexually transmitted diseases
___	☐	☐	___ Social support system

I restrict sharing of information as follows:

_____

_____

_____(OVER)

MY RIGHTS

I understand that generally Sheridan Health Services (SHS) may not condition my treatment on whether I sign an authorization form. I also understand that in certain limited situations, I may be denied treatment if I do not sign an authorization form. For example, if funding for my treatment depends on an agency or an organization receiving reports about my treatment and my progress, I will need to sign an authorization form or I may not be admitted to care. I also understand that the people who get this information may give out my information. As a result, the information may no longer be protected. SHS will try to prevent my information from being revealed by providing a notice to those receiving my information that redisclosure of personal information provided to them is not allowed.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 & 164. I understand that they cannot be released without my written permission unless otherwise provided for by the regulations.

I understand that if I sign this, I have a right to change my mind. If I decide I want to cancel this authorization, I must do so in writing. My cancellation will not affect any actions that have already been taken in the use of this authorization, such as confidential information that has already been shared between my care providers.

I understand that I will be given a copy of this permission once I have signed and dated it.

This authorization expires one year from the date I sign the form or when the sharing of information is longer needed to manage or to provide services to me, whichever happens first.

By signing this authorization, I agree that I have read and understand the information on this form.

_____	_____
Individual's signature	Date
_____	_____
Signature of Parent, Guardian and/or Authorized Representative (describe relationship) with legal authority to sign for individual	Date
_____	_____
Authorized Representative (describe relationship)	Date
_____	_____
Witness	Date

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AUTHORIZATION TO USE AND RELEASE CONFIDENTIAL HEALTH INFORMATION

Release From/To: Sheridan Health Services, Inc.

☐ Community Clinic
3525 W. Oxford Ave, Unit G3
Denver, CO 80236
Phone (303) 315-3150
Fax (303) 797-4266

☐ School Based Clinic
4107 S. Federal Blvd
Englewood, CO 80110
Phone (303) 781-1636
Fax (303) 783-9978

Release From/To:
_____
_____
_____
Phone ( ) _____
Fax ( ) _____

Individual's Name_____ _____/_____/_____
Last name, First name, Middle Initial – please print — Individual's Birth Date

Address_____ Phone ( ) _____

City, State, Zip Code_____ Phone ( ) _____

I, _____ _____
Individual's name or name of person authorizing release of information — legal authority to sign for individual

give my permission to use and release my confidential health information between the parties identified above. I understand that by giving my permission, I will receive better coordinated quality health care. The focus of my care is on the whole person, with an individualized care plan developed for me. Only the amount of information reasonably necessary to achieve the purpose of this authorization will be shared.

CONFIDENTIAL HEALTH INFORMATION THAT MAY BE SHARED

I understand that confidential health information or records that may be shared includes:

YES	NO	*(Please Initial)*	YES	NO	*(Please Initial)*
___ ☐	☐ ___	My diagnosis (the name of my disease or problem) and any allergies	___ ☐	☐ ___	My mental health status (not including psychotherapy notes)
___ ☐	☐ ___	Results of my lab tests, x-rays, urine tests and any other tests	___ ☐	☐ ___	Trauma history
___ ☐	☐ ___	Past/current medications prescribed to me, including dosage	___ ☐	☐ ___	My drug or alcohol use
___ ☐	☐ ___	My contact information, including name, phone, address, etc.	___ ☐	☐ ___	HIV/AIDS status
___ ☐	☐ ___	Information about me, including gender, ethnicity, age, employment information, etc.	___ ☐	☐ ___	Sexually transmitted diseases
			___ ☐	☐ ___	Social support system

☐ I restrict sharing of information as follows:

_____

I understand that the people who get this information may give out my information. As a result, the information may no longer be protected. If I am receiving alcohol and/or drug treatment from SHS, I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 & 164. I understand that they cannot be released without my written permission unless otherwise provided for by the regulations.

I understand that if I sign this, I have a right to change my mind. If I decide I want to cancel this authorization, I must do so in writing. My cancellation will not affect any actions that have already been taken in the use of this authorization, such as confidential information that has already been shared between my care providers.

I understand that I will be asked if I want a copy of this permission once I have signed and dated it.

This authorization expires one year from the date I sign the form or when the sharing of information is longer needed to manage or to provide services to me, whichever happens first.

By signing this authorization, I agree that I have read and understand the information on this form.

_____ _____
Individual's signature — Date

_____ _____
Signature of Parent, Guardian (describe relationship) with legal authority to sign for individual — Date

_____ _____
SHS Clinical Staff Witness, Credentials — Date

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CLIENT RIGHTS

While at Sheridan Health Services (SHS):

1. It is a client's right to not be discriminated against because of race, color, creed, gender, sexual orientation, or disability.
2. Clients have the right to be treated with respect, impartiality, and fairness.
3. Clients shall be informed of Sheridan Health Services rules and hours.
4. Clients have the right to review their case records. The client may, upon request, review the case file or it can be released or viewed by others only with a proper, signed release of information form from the client. Such reviews of the file may be conducted according to program procedures, at a time convenient to the facility and the reviewer. Professional staff must be present to explain the materials. The program may remove the following kinds of confidential information before the client or others see the file:
    A. Information that may threaten the security of the facility or the confidentiality of other clients.
    B. Information that may result in other peers being put in danger of physical injury
    C. Information which, if revealed, would be psychologically damaging.
5. Clients have a right of freedom of expression as long as it does not interfere with the rights of others.
6. Clients have the right to receive services in the least restrictive setting, subject to available resources and appropriations.
7. Clients have the right to an individualized service/treatment plan and to participate in its development and any subsequent changes in the plan.
8. Clients have a right to due process in disciplinary proceedings.
9. Clients will not be discriminated against for exercising their rights.

I have read and I understand the Client Rights document, and I have been offered a copy.

Client Signature _____ Date _____

Parent/Guardian Signature *(if applicable)* _____ Date _____

Therapist Signature _____ Date _____

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Client Name _____ Date _____

APPOINTMENT POLICY

Welcome to Behavioral Health, Outpatient Substance Use Treatment, and Psychiatric Nursing Services at Sheridan Health Services (SHS). We encourage you to come to all scheduled appointments. Any change to your appointment may affect other clients. If an appointment is not kept, it generally means that someone else was not able to receive services.

We request that both new and established clients provide **at least a 24-hours' notice** of cancellation of their appointment.

If three (3) appointments are cancelled or missed with less than 24-hours' notice in a three-month period, we may terminate behavioral health, outpatient substance use treatment, and/or psychiatric nursing services. Additionally, if you are 15 minutes late for your appointment, we may have to reschedule your appointment. We may also terminate behavioral health, outpatient substance use treatment, and/or psychiatric nursing services if you are consistently late for appointments within a three-month period. At the time of termination, we will provide you with information about other referral sources, if necessary. Behavioral Health Providers and/or Nurse Practitioners reserve the right to change this policy due to extenuating circumstances.

FEE AGREEMENT

It is the policy of SHS to maintain costs and fees that are consistent with locally prevailing rates or charges and are designed to cover the reasonable costs of operations for services provided to our clients. We make every reasonable effort to obtain reimbursement from third party payors including public insurance programs such as Medicaid, CHP+, Medicare and other public assistance programs, as well as private health insurance. Clients with third party coverage from public or private programs are expected to pay any required co-payments, deductibles, or co-insurance for services at the time of service.

All clients may apply for the Sheridan Sliding Fee Discount Program. This program applies to all clients and families with annual incomes at or below 200 percent of the Federal Poverty Guidelines.

All clients are charged based on the SHS fee schedule.

- Sliding Fee Scale clients will be billed and charges adjusted according to their discount rating.
- Third party insurance companies will be billed based on insurance plan, and co-payments, deductibles, or co-insurance may be due at the time of service.
- Clients not eligible for the Sheridan Sliding Fee Discount Program, or without insurance or another discount program are subject to full charge prices. A prompt pay discount is available for these charges, please ask to speak to the patient account representative.

I have read and understand the appointment policy and fee agreement.

Client Signature _____ Date _____

Parent/Guardian Signature *(if applicable)* _____ Date _____

Provider/Witness Signature _____ Date _____

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ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the joint Notice of Privacy Practices for University of Colorado Anschutz Medical Campus and Sheridan Health Services.

_____ _____

Name (Sign) Date

_____

Name (Print)

_____

For Internal Use Only:

Reason Acknowledgment was not obtained: _____

_____

_____

_____

_____ _____

Name (Sign) Date

_____

Name (Print)