Consent for Remote Teleservices

1. I authorize Center For Family Services to provide me with remote teleservices.
2. The type of service to be provided remotely via teleservices, includes but is not limited to:
   _____
   _____
   _____
3. I understand that this service is not the same as in person services, because I will not be in the same room as the provider performing the service.
4. I understand the purpose of the videoconferencing and teleconferencing technology and the risks, benefits and complications (from known and unknown causes) that may arise during remote services. The risks of not using remote teleservices have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. Center For Family Services utilizes technology that is compliant with HIPAA regulations to protect my confidentiality and the information being transmitted. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that Center For Family Services or I can discontinue the teleservices if technical issues prevent services from being provided appropriately.
6. I understand that the teleservices session(s) may not be audio or video recorded at any time by Center For Family Services, the staff or myself.
7. I acknowledge that I have the right to request the following:
   a. Asking non-service personnel to leave the room at any time if not mandated for safety concerns,
   b. Termination of the service at any time.
8. My consent to participate in teleservices shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
9. I agree that there have been no guarantees or assurances made about the results of this service.

_____ _____

Patient/Relative/Guardian Signature* Print Name

_____ _____

Relationship to Patient (if required) Date

_____ _____

Staff Signature Date

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

** See Virtual Admission Procedures

CHARITABLE CHOICE NOTICE

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious or non-religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

I have received and understand this document advising me of my right to charitable choice:

Client Name _____ Date _____

Client Signature _____

CENTER FOR FAMILY SERVICES

Vision, Hope and Strength for a Better Life

CLIENT NOTICE
Federal Law 42 C.F.R. Part 2

Confidentiality of Substance Use Disorder Client Records:

The confidentiality of clients in alcohol and drug treatment is protected by Federal Law and Regulations. This law guarantees the strict confidentiality of information about persons receiving treatment services. Generally, the program may not say to a person outside the program, that a client attends the program or disclose any information identifying a client as having a substance use disorder UNLESS:

1. The person consents in writing;
2. The disclosure is allowed by a special court order;
3. The disclosure is made to medical personnel in a medical emergency when patient is unable to provide informed consent;
4. The disclosure is made to qualified personnel for research, audit, or program evaluation.

Federal Law and Regulations DO NOT protect any information about a crime committed by the client, either at the program or against any person who works for the program. It does NOT protect any information about any threat to commit such a crime.

Federal Law and Regulations DO NOT protect any information about suspected child abuse and/or neglect from being reported under state law to appropriate state and local authorities.

REFERENCE FOR LAWS AND REGULATIONS: 42 C.F.R. Part 2 for Federal Regulations

VIOLATIONS OF FEDERAL LAW AND REGULATIONS BY A PERSON IS A CRIME.
Suspected Violations may be reported to New Jersey, U.S. Attorney's Office
https://www.justice.gov/usao-nj
U.S. Attorney's Office
970 Broad Street, 7th Floor
Newark, NJ 07102
Main number: 973-645-2700
Hearing Impaired: 973-645-6227

_____
Client Name (please print)

_____ _____
Client Signature Date

Vision, Hope, and Strength for a Better Life

AUTHORIZATION FOR RELEASE OF INFORMATION

FOLLOW UP RECORDS

I, _____, hereby give permission to the **Center For Family Services** to call me **within nine months from date of discharge to answer the follow-up questions in relationship to my treatment.**

No personal information will be released to anyone. "Data" related to the questions on the form will be used for agency evaluation and statistics.

The purpose or need for this disclosure is to determine the outcome of the treatment experience. This information may be given once.

This consent is subject to revocation at any time, ***in writing***, exept to the enxtent that action has been taken in reliance thereon, and will otherwise **expire twelve months from the date of discharge.**

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.

_____ _____

Signature of Client Date Signature of CFS Staff Date

_____ _____

Signature of Parent / Guardian Date Description of Authority if signing on behalf of client

NOTICE TO RECIPIENT

This information has been disclosed to you from records, which may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. 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 individual with substance use disorder."

NJ Division of Addictions Services requires treatment providers to provide all clients with referrals for Tuberculosis and HIV/AIDS Pre- and Post-Test Counseling.

AIDS / HIV Program - Provides free anonymous / confidential HIV counseling and testing. Provides risk assessment and education to "at-risk" individuals. HIV positive individuals are provided with standard blood profiles (Viral Load and CD4) and partner notification. The HIV Program is the entry point for HIV positive individuals to appropriate medical, dental, housing and social services. Educational programs are available upon request. Appointments at all locations are preferred. For information, or to make an appointment, please call (856) 374-6370.

East Camden Regional Health Center
Phone: (856) 968-2304
2631 Federal Street
Camden, NJ 08103
Hours: Mon – Fri 8:00a.m. To 4:00 p.m. (can vary)

Tuberculosis Control Program - Provides testing, treatment, and medical supervision of suspected or diagnosed cases of tuberculosis, educational presentations.

Phone: (856) 756-2266
2631 Federal Street
Camden, NJ 08103
Hours: Mon. – Fri.: 8:30 a.m. to 4:00 p.m. Wed.: 1:00 p.m. to 3:00 p.m. Clinic Session

STD Clinic Sites and Times

Paulsboro Clinic
1000 Delaware Street, Paulsboro
First and third Tuesday of the month
4:00 pm to 5:30 pm - No appointment necessary

Washington Township Clinic
204 East Holly Ave., Sewell
Every Wednesday from 3:00 to 4:30 pm. – No appointment is necessary

Washington Township Clinic; also offers

Tuberculosis Clinic

Patients diagnosed with or exposed to Tuberculosis are followed through a course of treatment to cure active disease or to protect the exposed patient from active disease.

Tuberculin testing (Mantoux – pronounced "man-too," PPD, or skin testing) is provided to the public on the second and fourth Monday of every month on a walk-in basis from 9:00 to 11:00 am. Tuberculosis Clinic is held on the second and fourth Wednesday of every month by appointment only.

HIV-Only Clinic

HIV counseling and testing is also provided by our nursing and clinical staff for those who require HIV testing only. This program offers the same HIV counseling and testing as the STD clinic. This clinic does not diagnose or treat AIDS. We discuss risk factors and risk reduction strategies for people 18 years of age and older. Every Thursday from 4:00 to 5:30 pm – No appointment necessary

Client Signature _____ Date _____

Counselor Signature _____ Date _____

The Center for Family Services, Inc.

Client Rights & Responsibilities

Client Rights & Responsibilities were established with the expectation that observance of these rights will contribute to more effective client care and greater satisfaction for the client, family, clinician and agency. Clients shall have the following rights without regard to age, race, color, sexual orientation, national origin, religion, culture, physical handicap, personal values or belief systems.

The Client Has The Right To:

- ~ Receive the professional care needed to regain or maintain his or her maximum potential.
- ~ Expect clinical staff who provide service to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality.
- ~ Expect full recognition of individuality, including privacy in treatment and care, with confidentiality kept in regards to all communications and records.
- ~ Complete information, to extent known, regarding diagnosis and treatment.
- ~ Be fully informed of the scope of services available at the agency, emergency resources, and related fees for services rendered.
- ~ Be a participant in decisions regarding the intensity and scope of treatment. If the patient is a minor, or unable to participate in those decisions, the patient's rights shall be exercised by the patient's legal guardian.
- ~ Refuse treatment to the extent permitted by law and be informed of the consequences of such a refusal. The client accepts responsibility for his or her actions should he or she refuse treatment or not follow the treatment plan agreed on.
- ~ Approve or refuse the release of records to any individual outside the agency, except as required by law or third-party payment contract.
- ~ Be informed of research/educational projects affecting his or her care or treatment, and can refuse participation in such research without compromise to usual care.
- ~ Express and / or file grievances/complaints and suggestions at any time, without interference or retaliation**.**
- ~ Change primary clinician if other qualified clinicians are available.
- ~ Be fully informed and involved before any transfer to any other service provider or organization.
- ~ Express those spiritual beliefs and cultural practices that do not harm others or interfere with agency

Clients also have:

1. The right to be free from unnecessary or excessive medication (see N.J.A.C. 10:37-6.54)
2. The right to not be subjected to non-standard treatment or procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the clients' choice
    i. If the client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30L4-24.2(d) 2
3. The right to treatment in the least restrictive setting, free from physical restraints and isolation, provided, however, that a client in inpatient care may be restrained or isolated in an emergency pursuant to the provisions of N.J.S.A.30:4-24.2d(3)
4. The right to be free from corporal punishment
5. The right to privacy and dignity
6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.

See other side / next page for Local / State contact information for concerns, advocacy and resources.

The Client Is Responsible For:

- ~ Being considerate of other clients and personnel and for assisting in the control of noise, smoking, eating, and other distractions.
- ~ Respecting the property of others & the facility.
- ~ Reporting whether he or she clearly understands the treatment plan and what is expected of him or her.
- ~ Keeping appointments and, when unable to do so for any reason, notifying the facility 24 hours in advance.
- ~ Recognizing that the given appointment time is dedicated to the client, and arriving on time for that appointment.
- ~ Providing the clinician with the most accurate and complete information regarding present concerns, past history, hospitalizations, medications, changes, or any other client health or circumstance matters.
- ~ Observing the rules of the agency during his or her treatment and, if instructions or agreed plan is not followed, forfeits the right to care at the agency is responsible for the outcome.
- ~ Promptly fulfilling his or her financial obligations to the agency.
- ~ Reporting any change in insurance, financial ability, and status.

Grievance Procedure:

If a client feels he/she has a grievance, attempts should be made to resolve the concern with the counselor. If this does not resolve the issue, the client may ask to see the Program Director. In consultation with the VP, the Program Director will respond to the complaint within ten days. The decision is made in writing with copies going to the client.

If there is still no resolution, the client may appeal directly to the Vice President and/or CEO/President of the Agency, who is responsible to address the complaint within fifteen working days. If the decision does not meet the needs of the client, the client may then request in writing a conference with the Executive Committee of the Board, who will arrange a conference within fifteen working days. While these hearings are informal, the client may bring a person of their choice with them to assist in presenting the concern. At a grievance conference, the client, witnesses & staff shall have equal opportunity to:

*Present and establish relevant facts
*Discuss, question or refute material
*Examine relevant records available

The Executive Committee's decision is made in writing, and copies go to the client, CEO, and on file with the Committee. The Agency will maintain confidentiality in all client grievance procedures and information.

At any point, the client may contact an outside agency to respond to concerns or provide praise for services. A list of resources is listed on the other side / next page.

Revised: 2019 July 25

I have read and received a copy of the Client Rights and Responsibilities for the Center for Family Services, Inc.

Name: _____ Date: _____

State and Local Concerns / Support Resources

Camden County

Camden County
Mental Health Administrator
John Pellicane
DiPiero Center, 512 Lakeland Rd, Suite 301
Blackwood, NJ 08012 856-374-6320

Community Health Law Project
Station House Office Building
900 Haddon Avenue, Suite 400
Collingswood, NJ 08108
856-858-9500

Mental Health Advocate of the
Prosecutor's Office
Camden County 856-225-8400

Gloucester County

Gloucester County
Mental Health Administrator
Rebecca DiLisciandro
115 Budd Blvd, West Deptford, NJ 08096
856-483-6889

Mental Health Advocate of the
Prosecutor's Office
Gloucester County 856-384-5500

Atlantic County

County Mental Health Board
Atlantic County Mental Health Administrator
Kathleen Quish
101 South Shore Road
Northfield, NJ 08225
609-645-7700 Ext. 4519

Mental Health Advocate of the
Prosecutor's Office
Atlantic County 609-909-7800

NJ State Wide

Margaret Molnar, Special Assistant for
Consumer Affairs, DMHAS
5 Commerce Way, Suite 100, Hamilton, NJ 08691
609-438-4338

Disability Rights New Jersey
210 South Broad Street, 3rd Floor
Trenton, NJ 08608 Gwen Orlowski
1-800-922-7233 and 609-292-9742

Division of Mental Health Advocacy
Justice Hughes Complex
25 Market St, Trenton, New Jersey 08625
877-285-2844

NJ Division of Consumer Affairs
973-504-6200

NJ Division of Mental Health Services
800-382-6717

The Mental Health Association in
Southwestern New Jersey 856-522-0639

NJ Division of Addiction Services
609-292-5760

Division of Child Protection and Permanency
1-877-NJ ABUSE (652-2873)
1-800-835-5510 (TTY/TDD)
24 hours a day - 7 days a week

Division of Children and Families
Office of Advocacy
1-877-543-7864

NJ Department of the Public Advocate
609-826-5057

Office of the Ombudsman for the
Institutionalized Elderly
1-877-582-6995

Other Services and Resources:
Dial 211

Group Rules

1. Abstinence from all mood-altering chemicals (including alcohol) is mandatory. _____
   Initial Here
2. No sexual harassment, advances/gestures, or fraternization toward other clients or staff members. (This included engaging in sexual activity and intimate relationships with group members)
3. No physical violence or threats of physical violence.
4. CONFIDENTIALITY is a must and is to be honored. All matters discussed in group are to stay in group.
5. Hats or clothing advertising or promoting alcohol/drugs are strictly prohibited.
6. Maintain respect for other people and property, showing respect for others' beliefs and opinions.
7. All clients are expected to actively participate in the group process.
8. No one is permitted in the building under the influence of drugs/alcohol.
9. RANDOM URINALYSIS: When you are asked to give urine, it must be given that night or it will be counted as POSITIVE and you may be discharged for NON-COMPLIANCE.
10. NO FOOD OR DRINKS ALLOWED IN GROUP except for water.
11. **Cellular phones are not allowed in session.**
12. MISSING GROUP IS NOT ACCEPTABLE! If an emergency arises and you must miss, you must call your counselor at The Center for Family Services, Inc, (856) 963-0200, twenty four (24) hours in advance or you will be marked as No Call/No Show and your referral source will be contacted.
13. TARDINESS: Please try to arrive ten (10) minutes before group to complete the process at the front desk. Lateness for group is not acceptable.
14. NO SMOKING IN THE BUILDING OR ON THE GROUNDS OF AGENCY PROPERTY. Clients are expected to go off grounds if they intend to smoke. Nicotine cessation assistance is available. Speak with your counselor.
15. In the event of bad weather, call (856) 964-1990 after 8:00AM and listen to voice mail directions regarding group cancellations.

Client's Signature: _____ Date: _____

AGENCY STATEMENT OF CLIENT'S RIGHTS
AND
AGREEMENT TO ACCEPT TREATMENT

The Center For Family Services' Substance Use Disorder Program's various services and programs are formulated to extend to each client a comprehensive package of rights and privileges. Clients, however, are also entrusted with a number of expectations and responsibilities, which must be respected and maintained.

Prior to the signing of this contract, please read it carefully.

AS A CLIENT OF THE CENTER FOR FAMILY SERVICES, YOU HAVE THE FOLLOWING RIGHTS:

1. You have the right to have an individual counselor. You also have the right to a minimum of three (3) hours per week of counseling at a mutually agreeable time. In addition, you have the right to confidentiality concerning what is said and done during individual and group meetings.

2. You have the right to know that no information will be released specific to you or what is discussed in the counseling setting unless you voluntarily sign an authorization to release information, which specifies what information is to be released, for what purpose, to whom, and how many times. The Federal Confidentiality Regulation protects you.

3. You have the right to request to know the contents of your personal file. Your request will bring about a clinical staff review of your file and the manner in which the information will be released to you within a period not to exceed two weeks.

4. You have the right to avail yourself of any and all of the Center For Family Services' services including individual, peer group, family education, vocational training and any other service which you or your counselor deem appropriate for your treatment. This includes referral to other programs within the area: Federal, State, and County service-oriented organizations and the full service of the legal system.

5. You have the right to participate fully in developing any treatment plan in which you will be involved.

6. You have the right to be free from physical restraint and isolation except in emergency situations.

7. You have the right to be notified in writing of any decisions concerning your status with this program. In the event that you are dissatisfied with the decision, you may appeal it to your primary counselor, and secondly, the Program Director, which will result in a review of your case.

8. You have the right to be free from corporal punishment.

9. You keep the right to have your civil rights respected and protected during your treatment at Center For Family Services.

10. You have the right to read all correspondence, which you request we write on your behalf.

IN CONJUNCTION WITH YOUR RIGHTS AS A PARTICIPANT AT THE CENTER FOR FAMILY SERVICES, YOU ALSO HAVE RESPONSIBILITIES.

THEY ARE AS FOLLOWS:

1. You have the responsibility to be consistent, keep all appointments with your counselor, show up on time, and avoid interfering as much as possible in the other activities of the agency.

2. In the event that you must miss an appointment, call your counselor in advance so the counselor can more appropriately use the time.

3. To become familiar with and adhere to all agency rules and regulations, as well as, to Federal, State and Local Law.

CARDINAL RULES

Any violation of these rules is considered a serious matter and the individual will be required to appear before the Substance Abuse Counselor and the Substance Abuse Program Director.

1. No one is permitted in the building under the influence of drugs, alcohol or be in possession of it.

2. No sexual relationships with the clients or staff members.

3. No physical violence or threat of physical violence.

4. All matters discussed in the group are to stay in group. **Confidentiality** is a must and is to be honored.

5. Maintain respect for other people and property. No destroying, stealing or vandalizing.

Please sign and date:

I, _____, have read this statement of my rights and I am satisfied with them. Also, I agree to meet my responsibilities while I am a participant of any Center For Family Services, Inc. service.

_____ _____
Client's Signature Date

_____ _____
Witness Date

AGREEMENT FOR PAYMENT

The Center For Family Services considers being responsible for payment an important part of treatment. Therefore, it is essential that you understand your responsibility to pay for your treatment as indicated.

PLEASE READ AND SIGN:

I understand that if I am referred for outpatient treatment at Center For Family Services, I am responsible for the fee payments for treatment as well as Toxicology Screen costs, both of which are indicated below.

I understand that if I do not call into my counselor and notify them of a planned absence from treatment 24 hours prior to a group or individual session that I will be charged a $20 no show fee. This fee can and will include the assessment portion of the intake process.

I understand that payment is expected in cash or can be paid with a credit or debit card when services are rendered. I understand that I am expected to keep this account current and that I will not be allowed into my next treatment session if I am not current on my account.

I understand that my absence from treatment for more than ten days may result in my losing the funding that partially pays for my treatment. I further understand that my absence for more than thirty days may result in my discharge from the outpatient program.

If a need is indicated for a reduced fee, I will discuss this with my counselor. Any adjustments to this fee must include additional documentation and be submitted to the clinical team for approval. The clinical team has final authority on fee adjustments.

Toxicology Screen Fee	$ _____ per screen
Group Fee	$_____ per session
Individual Session Fee	$_____ per session
No Show Fee	$ 20.00 for any missed group session, individual counseling session, and/or assessment

_____	_____	_____
Client Name – Please Print	Client Signature	Date

Revised 2018

Vision, Hope and Strength for a Better Life

NOTICE OF PRIVACY PRACTICES

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

This notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996.

Center For Family Service is committed to protecting you personal information. We create a record of the treatment and services you receive at the Center. We need this record to ensure the quality, continuity and effectiveness of your care. In keeping with our caring culture, Center For Family Services strives to maintain a balance between protecting your privacy, providing quality treatment and ensuring your health and safety. This notice describe how we may use and disclose your protected health information to carry out treatment, payment, healthcare operations, ensure your health and safety, and for other purposed that are permitted or required by law.

This notice also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information such as gender, ethnicity, date of birth, diagnosis and telephone number that may identify you and that relates to your past, present or future physical or mental health, condition and related healthcare services.

Center For Family Services is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. A new notice will be effective for all protected healthcare or service information that we maintain at that time.

A copy of the Notice of Privacy Practices will be given to you at the time you first enroll for services at the Center For Family Services (for enrollments on or after April 14, 2003). Upon request, we will provide you with any revised Notice of Privacy Practices. A copy of our Notice of Privacy Practices is available on our website www.centerffs.org. Copies are also available from your program or the Agency's Privacy Officer:

Cindy Herdman-Ivins, Chief Administrative Officer
Center For Family Services
584 Benson Street
Camden, NJ 08103 856-964-1990

Acknowledgement of Receipt

_____ _____

Signature Date

CENTER FOR FAMILY SERVICES
Notice of Privacy Practices

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

Center For Family Services has a legal duty to safeguard your protected health information. All employees, volunteers, staff, doctors, health professional and other personnel are legally required to and must abide by the policies set forth in this notice, and to protect the privacy of your health information.

This "protected health information" includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) you Protected Health Information. With some exceptions, we may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of this notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the Protected Health Information already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy from the contact person listed at the end of this notice at anytime and can view a copy of the notice on our website www.centerffs.org

We may use and release your protected health information for many different reasons. Below we describe the different categories of when we use and release your Protected Health Information **without your consent.**

A. We may use, or disclose your protected health information for treatment, payment, or health care operations.

1. For Treatment. We may share your Protected Health Information among physicians, nurses, psychologists, social workers, interns, and other health care personnel who are directly involved in your health care at this agency. **For example:** your primary therapist and your medication provider will share your protected health information to provide the best care for you. For external disclosures we will always ask for your authorization before we disclose your health information, except in emergencies to other mental health agencies or units.

2. **To obtain payment for treatment.** We may use and release your Protected Health Information in order to bill and collect payment **from you** for services provided to you. It is important that you provide us with correct and up-to-date information. **For example:** we may release portions of your Protected Health Information to our billing department to get paid for the health care services we provided to you. We may also release your Protected Health Information to our business associates, such as billing companies.

3. **To run our health care business.** We may use your Protected Health Information internally, in order to operate our facility in compliance with healthcare regulations. **For example:** we may use your Protected Health Information to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. We do not require your consent to use or release your protected health information:

1. When federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies request your Protected Health Information. We release your Protected Health Information only when a law required that we report information to government agencies or law enforcement personnel. Specifically we would notify the New Jersey Department of Child Protection and Permanency about victims of child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred, in missing person cases; or when ordered in a judicial or administrative proceeding, or in accordance with 42 CFR Part II.

2. About Decedents. We provide medical examiners at their request, necessary information relating to an individual's death, or in accordance with 42 CFR Part II.

3. To avoid harm. In order to avoid a serious threat to your safety or the safety of another individual, we may provide your Protected Health Information to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.

4. **For appointment reminders and health-related benefits and services.** We may use your demographic Protected Health Information to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

5. For health oversight activities. We report information about serious incidents, including deaths, to the NJ Department of Human Services, and Department of Health and Senior Services. We may use and disclose your Protected Health Information. We may use and disclose your Protected Health Information to a health oversight agency, including NJ Department of Health and Senior Services, Medicaid, Medicare, or your Health Insurance Plan, for oversight activities authorized by law, including audits, licensure, or other activities necessary for oversight of the health care system or disciplinary actions against our workforce.

C. Your prior written authorization is required for any uses and disclosures of your protected health information not included above.

1. To obtain payment from your health care plan for treatment. Pending your signed Consent for Release of information and Payment for Medical Benefits Form, we may use and release your Protected Health Information to your health plan in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date information.

2. Information shared with family, friends, and others. We will only release your Protected Health Information to a family member, friend, or other person that you indicate is involved in your care if you agree to the disclosure by completing and signing an Authorization Form.

We will ask for your written authorization before using or releasing any of your Protected Health Information. If you choose to sign an authorization to release your Protected Health Information, you may later cancel that authorization in writing. This will stop any further release of your Protected Health Information for the purposes you previously authorized.

Your rights regarding your Protected Health Information

A. You Have the Right to Request Limits on How We Use and Release Your Protected Health Information. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit Protected Health Information that we are legally required or allowed to release.

B. You Have the Right to Choose How We Communicate Protected Health Information to You. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed on to you for payment.

C. You Have the Right to Request to See and Get Copies of Your Protected Health Information. You must make the request in writing. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You may have the right to have the denial reviewed by a committee. You can request a summary or a copy of your Protected Health Information as long as you agree to the cost in advance. If your request to see your Health Information is approved, we will arrange this in accordance with established policy. Please submit all requests for this information to the Director of the Program in which you are receiving services, or the Chief Administrative Officer.

D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your Protected Health Information. This list **will not** include uses you have already authorized, or those for treatment, payment or operations. This list will not include disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list will include dates when your Protected Health Information was released and the purpose, with whom your Protected Health Information was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to the Director of the Program in which you are receiving services, or the Chief Administrative Officer.

E. You have the Right to Correct or Update Your Protected Health Information. If you believe that there is a mistake in your Protected Health Information or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or release of your Protected Health Information. If we approve your request, we will make the change to your Protected Health Information, tell you that we have done it, and tell others that need to know about the change or amendment to your Protected Health Information. Please submit all requests for this information to the Director of the Program in which you are receiving services, or the Chief Administrative Officer.

F. You have the Right to Receive This Privacy Notice. You have the right to request another paper copy of this notice at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your Protected Health Information, you may file a complaint with our Privacy Official listed below. You also may send a written complaint to the Secretary of the Department of Human Services.

You will not be penalized for filing a complaint.

Person to contact for information about this notice or to voice your concerns about our privacy practices, please contact our Privacy Official, Chief Administrative Officer at 856.964.1990.

Effective date of this Law: April 14, 2003

INTERN SERVICES DISCLOSURE

Please be advised that the Center For Family Services, Inc. (CFS), Substance Use Disorder Services (SUDS), employs Alcohol and Drug Counselor Interns in a variety of positions and tasks. These interns may have completed the coursework required for their certification (CADC) and are fulfilling the experience requirement towards it. Some have fulfilled all the requirements and are waiting to take the final examinations. Each intern has gone through the rigorous hiring process required by CFS and by the New Jersey Department of Mental Health and Addiction Services Standards for Licensure of Outpatient Substance Abuse Treatment Facilities. They are supervised by a licensed professional on a weekly basis.

The following staff members are currently Alcohol and Drug Counselor Interns:

Family First Program
Lily Duncan, LAC
Rosemary Garcia, LSW
Elise Vermane, MS
Adaugo Anusionwu, MPH
Melyssa Totten, BSW
Supervisor: Shannon Peterson-Hoelter, LPC, LCADC

Pathways to Recovery Program
Maria Perdunn, MSW
Peter DeStefano, MS
Julio Sanchez, BA
Supervisor: Octavius Brown, LPC, LCADC

Recovery Network for the Deaf, Hard of Hearing and Hearing Loss
Julie Doerrmann, AAS Supervisor: Linda Mur, PhD, LCADC

In addition, the agency provides practicum and internship experiences each year for a variety of counseling and social work students from colleges and universities. They will be introduced by staff as interns.

If you have any questions, comments or concerns about the status of anyone present during a program session, please feel free to discuss them with your counselor.

I understand that the person providing services to me may be an Alcohol and Drug Counselor or other student intern.

_____
Client Name (please print)

_____ _____
Client Signature Date

Revised 1.23.2020