TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Demographic Information

First and Last Name:		**Date:**
Address:		**City, State and Zip**
County of Legal Residence:		
Home Phone ( )	**Cell ( )**	**Work ( )**
Where may we contact you? (Circle) Home Cell Work		
Where may we leave a message? (Circle) Home Cell Work		
Age:	**Date of Birth:**	**Social Security Number:**
Gender: (Circle) Male Female	**Marital Status:** (Circle) Married Single Divorced Widow Separated Other	
Race: (Circle) White Multiple Race African American Asian Alaskan Native Native American		
Primary Language: (Circle) English Spanish Other	**Client Needs assistance of an interpreter?** ( ) Yes ( ) No If Yes: American Sign Language or Language Interpreter	
Client needs assistance with visualization of material or alternate format? ( ) Yes ( ) No		
Advance Directive? (Circle) Yes (if yes, please supply us a copy of the directive No (if no, ask if client needs assistance in obtaining an advance directive)		
Parent/Guardian/Custodian if Minor (Name, Address and Phone Number)		
Emergency Contact and Relationship (Name, Address and Phone Number)		

Insurance

Medicaid MMIS#	Medicare Number:
Primary Insurance ID#	Group Policy #
Secondary Insurance ID#	Group Policy #

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HIPAA Acknowledgement

Client Printed Name: _____

I hereby acknowledge, with my signature below, that I have received a copy of the Travco Behavioral Health, Inc. Privacy (HIPAA) Notice, Client Rules and Expectations, Client's Rights and Grievances, and the Client Handbook.

The Mahoning County Mental Health Board

Receipt of Notice of Privacy Practices

I acknowledge, with my signature below, I have received a copy of the "Notice of Privacy Practices" from the Mahoning County Mental Health Board (MCMHB). I understand the information in the notice and know that I may ask for further clarification by contacting the MCMHB at 330.746.2959, ext 7978.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

TRAVCO
Behavioral Health
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Standard Financial Agreement

Commercial Insurance

Name: _____

DOB: _____ Social Security Number: _____

TRAVCO BILLING RATES		SELF PAY RATE
Physician (Psychiatric) Assessment	$251.99	$200.00
Initial Assessment	$156.99	$100.00
Individual Counseling (30 minutes)	$75.00	$35.00
Individual Counseling (60 minutes)	$155.00	$60.00
ASAM/AOD Assessment	$155.00	$60.00
Case Management (30 minutes)	$39.08	$35.00
Case Management (60 minutes)	$78.16	$60.00
Urine Drug Screen	$14.48	$10.00

Intensive Outpatient Therapy (see contract) IOP $300.00

This includes 12 sessions and 3 drug screens.

Medication Assisted Treatment Program (Suboxone/MAT) starts at $350.00

***If financial hardship should occur and/or insurance does not pay, self-pay rates will apply**

Client/Guardian: _____

Clinician Signature: _____

TRAVCO
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Insurance Agreement

I am aware that I am responsible for paying in full any services not covered and any co-payments set forth by my insurance company or any third party payer. I give the Provider Agency (Travco) authorization to file a claim for my services with my insurance company or any third party payer. I authorize the release of any medical information needed for the purpose of processing my claim as long as there is a balance due from_____ (Client name). I hereby authorize my insurance company or any third party to pay the Provider Agency (Travco) directly for any eligible services billed.

If for any reason I should receive the insurance check, I understand and agree to forward either the insurance check (endorsed on the back), money order OR cash for the exact amount of the insurance payment to the Provider Agency within (7) days from receipt.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Witness Signature Date

Policy for Cancelation of Appointments

It is very important to establish a policy regarding a cancelation for missing therapy appointments. A charge is levied because a late cancellation or no show potentially represents any income loss that might be significant percentage of the practitioner's daily income. The established policy requires that you call our office at least 24 hours in advance. A charge of ($25.00) may be assessed on the first no show with your therapist. After the second no show with your therapist the full fee may be assessed. You should be made aware that insurance companies *do not* pay for treatment that has not actually been rendered. As in all medical practices a short delay might still occur in the starting time of your appointment due to reasons beyond control (e.g. crisis interventions, phone calls from emergency rooms, etc.)

I have read and agree to the contents of the above policy.

_____

Signature Date

_____

Guardian Date

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Policy: CLIENT ORIENTATION CHECKLIST Effective Date: July 1, 2009

Approved By: Governing Board of Directors Review Date: July 1, 2019

Client Name: _____

- ☐ Explanation of Client Rights
- ☐ Explanation of grievance and appeal procedure
- ☐ Explanation of the ways they can give input regarding the quality of care, achievement of outcomes, and client satisfaction
- ☐ Explanation of the services and activities offered
- ☐ Hours of operation
- ☐ Access to after-hour services
- ☐ Code of ethics
- ☐ Confidentiality policy (HIPAA)
- ☐ Requirements for follow-up if the client has been mandated to treatment, regardless of the treatment outcome
- ☐ Explanation of financial obligations, fees and financial arrangements for services
- ☐ Familiarization with the premises including emergency exits, fire extinguishers, and first aid kits.
- ☐ A copy of general program rules regarding seclusion/restraint, smoking drugs, weapons, any other restrictions, events, behaviors, or attitudes that may lead to the loss of rights or privileges of the client, and by which the client may regain these rights or privileges
- ☐ Identification of the primary person responsible for treatment coordination
- ☐ Education regarding advanced directives, when appropriate
- ☐ Identification of the purpose and process of assessment
- ☐ Description of how the treatment plan will be developed and the client's participation in it
- ☐ Information regarding discharge criteria and procedures

By signing, I am agreeing that all the above checked items have been reviewed with me.

Client Signature/Date Staff Signature/Date

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Policy and Procedure Manual

Policy: Client Rights – Mental Health Policy Policy#E-19 **Effective Date: July 1, 2009**

Approved By: Governing Board of Directors **Review Date: July 1, 2019**

Policy:
It is the policy of TRAVCO to ensure that all clients know and understand their rights.
Purpose:
To establish a policy to ensure the rights of all clients at TRAVCO.
Procedure:
Clients will be given a handbook which outlines their rights as a client. During orientation, the counselor will review the client's rights to ensure the client understands their rights, as indicated by the client signature at the bottom of this document. For persons served in a program longer than one year staff will review client's rights annually and document this with the client signature.
Mental Health client's rights are as follows:

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
2. The right to service in a humane setting which is the least restrictive feasible as defined in the treatment plan.
3. The right to be informed of one's condition, of proposed or current services, treatment or therapies, and of the alternatives.
4. The right to consent to or refuse any services, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any services, treatment, or therapy on behalf of a minor client.
5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of the appropriate and adequate services, as available, either directly or by referral.
6. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.
7. The right to freedom from unnecessary or excessive medication.
8. The right to freedom from unnecessary restraint or seclusion.
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the clients participation in other services. This necessarily shall be explained to the client and written in the client's current service plan.
10. The right to be informed of and refuse any unusual hazardous treatment procedures.
11. The right to consent or refuse involvement in research projects.
12. The right to be informed consent or refusal or expression of choice regarding the composition of the service delivery team.
13. The right to be free from humiliation, neglect, and abuse.
14. Freedom from financial or other exploitation.
15. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies or photographs.
16. The right to access or referral to legal entities for appropriate legal representation at one's own expense.
17. The right to access self-help and advocacy support services.

Client Rights Officer-Cindy O'Keefe, Clinical Director-Hours available; Monday thru Friday 8:00am to 5:00pm and through the Help line after hours. Phone (330)286-0050

18. The opportunity to consult with independent treatment specialties at one's own expense.
19. The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court appointed guardian of the person of an adult client in accordance with rule 5122:2-3-11 of the Administrative Code.
20. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the clients treatment plan. "Clear treatment reasons" shall be understood to mean only serve emotional damage to the client such that dangerous or self-injurious behavior is an eminent risk. The person restricting the information shall explain to the client and other persons authorized by the client factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records.
21. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
22. The right to receive an explanation of the reasons for denial of service.
23. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay.
24. The right to know the cost of service.
25. The right to be fully informed of all rights.
26. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service.
27. The right to file grievance.
28. The right to have oral and written instructions for filling a grievance.

It is the responsibility of the Clinical Director:

a. To serve as a Client's Rights Advisor
b. To ensure that all clinical staff are knowledgeable of the existing client's rights.
c. To ensure that all support staff are knowledgeable of the existing client's rights.
d. To adopt procedures that ensure the client's rights are protected.
e. To review and investigate any client grievance.

It is the responsibility of the counselor:

a. At the time of intake the therapist shall give the client a copy of the Client Handbook, which lists the client's rights and grievance procedures.
b. The counselor will then ask the client to sign an Agreement for Services Form, which includes a statement that the client has received and understands his/her rights and grievance procedures.

It is the responsibility of all staff:

a. To be aware of and abide by the principles of this policy.

_____

Client Signature/Date

Client Rights Officer-Cindy O'Keefe, Clinical Director-Hours available; Monday thru Friday 8:00am to 5:00pm and through the Help line after hours. Phone (330)286-0050

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Policy: Acknowledgement of HIPAA **Effective Date: July 1, 2009**

Approved By: Governing Board of Directors **Review Date: July 1, 2019**

Acknowledgement:

I hereby acknowledge that I have received a copy of the Travco Behavioral Health, Inc. (HIPAA) notice, Client Rules and Expectations, Client's Rights and Grievances, and the Client Handbook.

_____

Signature of Client Date

_____

Signature of Parent/Guardian Date

_____

Witness Date

TRAVCO
Behavioral Health
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Client Financial Obligation Policy

Please read the following terms of your financial obligation while receiving treatment at our facility. If there is something that you do not understand, please ask your counselor at this time. When finished, please sign below that you agree and understand your financial responsibility.

If you have insurance with a deductible and it has not been met, you the client are liable for pavement of the service after the claim is processed.

If you have copay with a deductible and it has not been met, you will be responsible to make the co-pay **BEFORE** you see your counselor.

If you do not have any type of Health Care coverage you may be put on a Self-Pay Agreement, if so, you will be responsible for payment before you see your counselor.

Some insurance companies will not cover drug testing or case management. As a courtesy to the client we will bill the insurance, but if the company denies payment you will be responsible for payment.

If you do not have your payment prior to services, *WE* have the right to refuse treatment. **ANY REPORTS NEEDED BY AN OUTSIDE SOURCE WILL NOT BE COMPLETED** until your financial obligation has been met in full.

Although we do contact your insurance company for mental health and/or substance abuse benefits, it is your responsibility to personally contact your insurance company and know what your benefits include. It is also the **CLIENT RESPONSIBILITY** to notify our billing department should insurance coverage change.

If, at anytime, your financial obligation has not been met, we have the right to suspend treatment until it has been met.

Client printed name: _____

Client signature: _____ **Date:** _____

Witness: _____

8261 Market St.
Boardman, Ohio 44512
Phone: (330) 286-0050 - Fax: (330) 286-0055

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Authorization for Disclosure of Confidential Information to Mahoning County Alcohol and Drug Addition Services Board's Billing Management Information System

I,_____, authorize

Travco Behavioral Health Services To disclose to

Mahoning County Alcohol and Drug Addiction Services Board (Board) and the Ohio Department of Mental health and Addiction Services (OhioMHAS) the following information:

My name and the other personal information and information about the services provided to me that is necessary to accomplish the following purposed:

- Enroll me in the billing management information system used by the Board, other county behavioral health boards and OhioMHAS
- Determine my eligibility for publicly-funded services
- Pay my provider for the publicly-funded services I receive
- Permit the Board to carry out its authorized legal responsibilities

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, my enrollment or eligibility for benefits, or payment for my services, except that I must authorize disclosure of this information to receive publicly funded alcohol and drug addiction services. I understand that my service provider may disclose information necessary to obtain payment for, and carry out authorized legal responsibility related to, my publicly-funded mental health services, including my enrollment in the publicly-funded system and determining my eligibility for those services, even if I do not authorize disclosure.

I understand that the information contained in the Board's billing management information system will only be used or disclosed by the Board of OhioMHAS as authorized by me or as permitted by applicable law. I understand that other county behavioral health boards that pay for services provided to me will only access information about me that is maintained in the Board's system and authorized by me or as permitted by applicable law.

I understand that me alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part2) and the Health Insurance Portability and Accountability Act of 1966 "HIPAA" (45 CFR 160 & 164) and cannot be disclosed without my written consent unless otherwise provided for in those federal regulations. I also understand that my mental health records are protected by Ohio Law and cannot be disclosed without my written consent unless disclosure is permitted by Ohio Law and HIPAA.

I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. If not previously revoked, this authorization will expire the time my treatment with Travco Behavioral Health Services ends.

I understand that I can lengthen or shorten this authorization period. I have been provided a copy of this form.

_____

Signature of Client/Legal Representative Date of Birth Date

Name and relationship of person signing on behalf of Client: _____

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Informed Consent for Treatment

Each treatment service that I receive has risks and benefits associated with it. The risks and benefits are outlined below and have been explained to me. My signature indicates that I wish to receive treatment and that I have had these benefits and risks explained to me as well as any others that may apply.

- **Diagnostic Assessment:** Diagnostic Assessment is an evaluation done to identify problems present. It indicated information received from the client in a variety of areas including stressors, health problems, medications, specific behaviors, hospitalizations, prior mental health treatment, etc.
- **Medication/Somatic:** The medication I am prescribed will help control or eliminate my symptoms. It may also have some side effects including but not limited to drowsiness, photosensitivity, tremors, diarrhea, muscle spasms, dry mouth, constipation, or blurred vision. My psychiatrist will explain to me the possible side effects and I should notify my psychiatrist if any occur. I understand that there is no absolute guarantee that this medication will help me. However, my psychiatrist has recommended it as it is his professional opinion that it will alleviate my symptoms. I cannot be forced to take medication. If I choose to discontinue against my doctor's advice, I do so taking the risk that my symptoms will recur and I may experience withdrawal symptoms. I understand I have the right to refuse any and all treatments. However, my service provider may also decline to provide me treatment if I refuse or cannot comply with the necessary requirements of that treatment.
- **Counseling/Psychotherapy:** I understand that therapy is a collaborative effort and that success or failure is a function of the efforts of both the therapist and me. Specific benefits of an effective therapy for me is outlined in my individual Service Plan. General benefits of therapy may include relief of symptoms, increased insight and confidence, and improvement in my daily functioning. I understand that verbal therapies may produce a temporary increase in stress due to the focus on problems, and professional literature suggests that approximately 10% of therapy clients become more dysfunctional as a result of the stress during treatment.
- **Supervision Notification:** The counseling staff of Travco Behavioral Health, Inc. is trained and qualified to be of assistance to you. In addition to his or her skills, your counselor may function under a supervisor and he or she may review your case with that supervisor. It also means that you have the right to meet with your counselor's supervisor at anytime upon request.
- **Client Rights:** I understand I have the right to refuse any and all treatments. However, my service provider may also decline to provide me a treatment if I refuse or cannot comply with the necessary requirements of that treatment. I understand that I have the right to withdrawal my consent for any and all treatments. If I refuse or withdraw from treatment, my service provider will make an effort to develop alternate approaches with me to get the service I need.

I hereby **CONSENT** to receive the services or for my child to receive the services for which I have signed and dated below

_____

Client/ Guardian printed name

_____

Client/ Guardian signature Date

_____

Service Provider Date

I hereby **WITHDRAW** my consent for the service recommended for me or my child

Client/Guardian: _____ Date: _____

Service Provider: _____ Date: _____

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Informed Consent for Prescription Medication

Client Name: _____ DOB: _____

I understand that my psychiatrist and/or medical provider at Travco Behavioral Health, Inc. has prescribed medication that may help my illness. I understand that results are not guaranteed.

My physician will inform me of the specific reasons why a medication prescribed, the potential benefits, the risk of the adverse side effects, likely outcome of no treatment and alternatives. I may receive a medication instruction handout(s) for the specific medication(s) that I will be taking, if requested.

I agree to take the medications only as prescribed. I agree to read the instructions on the medication bottle carefully, even if my doctor has already explained the medication, such as whether the medications should be taken on an empty or full stomach and whether it causes drowsiness.

I agree to keep all my attending doctors (including medical doctor, eye doctor, and/or dentist), plus my pharmacist informed of:

- My psychiatrist's prescriptions
- All other medication, prescription or nonprescription that I am taking
- Any medical conditions I have, especially heart disease, high blood pressure, seizures, ect.
- If I am allergic to my medication

If I am pregnant, suspect I may be, are breastfeeding, or intend to become pregnant while using the medication. I understand and have been informed that no medications have been proven to be completely without risk during the first trimester of pregnancy; I understand the dangers of consuming alcohol during pregnancy.

I understand that if I am prescribed a controlled medication, it is mandatory that the Ohio Automated RX Reported System (OARRS) will be reviewed and show the medication I am receiving and what physician is prescribing them, so similar medications are not being prescribed.

I agree to check with my pharmacist prior to purchasing over the counter medications, such as cold remedies, allergy pills, diet pills, antacid, etc., to see if they can be taken safely with my prescription.

I understand that if/ when psychiatrist or medical provider prescribes medication to me, I need to monitor my response to the first dose(s) of the medication, and agree that should I experience an adverse reaction, I will contact and inform my psychiatrist and/or medical provider. If I am at imminent risk/harm to myself, I will contact 911 OR go to the nearest **emergency room**.

I understand the danger of mixing alcohol with medications, and the danger of driving or operating heavy machinery while taking certain medications. I understand medication can cause drowsiness in some people. I will make sure I know how to react to it if I become sleepy; I will not drive, operate machinery or perform jobs that may become dangerous if I was not alert.

TRAVCO
Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Informed Consent for Prescription Medication

I understand certain medications my cause sensitivity to the sun. I am informed of this; I must wear sunscreen or protective clothing while outdoors. I am aware that certain medications may cause movement disorder, some irreversible (Tardive Dyskinesia) or sudden cardiac death. If I experience any side effects as a result of the medication(s); I will always notify my psychiatrist immediately. I will always notify Travco Behavioral Health, Inc. /my psychiatrist:

- If I can't adequately function or maintain daily activities while taking medication.
- Unusual symptoms appear such as: muscle twitching, stiffness, tremors, spasms, weakness, confusion, agitation, restlessness, blurred vision, skin rash, decrease or increase in appetite, heart palpitations, unusual tongue movements, persistent sore throat, menstrual irregularities, urinary or sexual difficulties, constipation or diarrhea.

I know I have the right to refuse or discontinue taking prescribed medicine(s), but I agree to inform my psychiatrist of my decision prior to discontinuation of the medication. I understand that I may not self adjust my medication, if I feel I need more or different medications, I need to call my doctor. I understand that treatment may be discontinued if I do not comply with the recommended therapy. I understand selling medications is illegal and I can be discharged from the program and/or agency if this happens.

I am willing to be patient and work with my physicians to find the correct medication and dosage that will be helpful to me. I understand not everyone will react or benefit in the same manner to a medication. I agree to keep an ongoing check on my supply of medication(s). I will make sure that I have enough to last until my next psychiatric appointment, through vacation, or over the weekend. I agree to notify Travco Behavioral Health one week in advance if I do not have a sufficient supply of medication.

I will always keep my supply of medication in the original bottle and will never mix the two medications in one bottle. I will keep all medications out of reach of children and pets. I will not leave my medication bottle lying out. I will be sure to replace the cap tightly with each use. I will keep medication in a cool, dry place. I understand that bathroom moisture tends to destroy medication.

I will not share my mediations with my family or friends. I understand that even medication that is especially helpful to me, may have a different effect on someone else or may react negatively with something they are taking.

Client Printed Name: _____

Client Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____

Travco Behavioral Health, Inc.
An Affiliation of First Step Recovery
NOTICE OF PRIVACY PRACTICES

Effective: February 23, 2015

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.

If you have any questions about this Notice, please contact*:*

Privacy Officer
Travco Behavioral Health
8261 Market St.
Boardman, Ohio 44512
(330) 286-0050

OUR DUTIES REGARDING YOUR HEALTH INFORMATION

At Travco Behavioral Health, Inc., we understand that health information about you and your health is personal. We are committed to protecting your health information and safeguarding that information against unauthorized use or disclosure.

When you receive services paid for in full or part by the Mahoning County Mental Health and Recovery Board, they receive health information about you. The information we receive may include, for example, eligibility, claims and payment information. We create a record of your enrollment in Ohio's public mental health and addiction services system and maintain that record and records related to the services you receive in the public system and payment for those services. We may also receive information from your treatment provider related to your diagnosis, treatment, progress in recovery, and any major unexpected emergencies or crisis you may experience to help the Board plan for and improve the quality of services paid for with Board funds.

We are required by law to: 1) maintain the privacy of your health information; 2) give you Notice of our legal duties and privacy practices with respect to your health information; 3) abide by the terms of the Notice that is currently in effect; and 4) notify you if there is a breach of your secured health information. This Notice will tell you about the ways in which we may use and disclose your health information. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use or share your health information for such activities as conducting our internal board business known as health care operations, paying for services provided to you, communicating with your healthcare providers about your treatment, and for other purposes permitted or required by law, as described in more detail below.

Payment– We may use or disclose your health information for payment activities such as confirming your eligibility, paying for services, managing your claims, conducting utilization reviews and processing health care data.

Health Care Operations – We may use your health information for our internal health care operations such as to train staff, manage costs, conduct quality review activities, perform required business duties and make plans to better serve you and other community residents who may need mental health or substance abuse services. We may also disclose your health information to health care providers and other health plans for certain health care operations of those entities such as care coordination, quality assessment and improvement activities and health care fraud and abuse detection or compliance, provided that the entity has had a relationship with you and the information pertains to that relationship.

Treatment – We do not provide treatment but we may share your health information with your health care providers to assist in coordinating your care.

Other Uses and Disclosures - We may use or disclose your health information, in accordance with specific requirements, for the following purposes: To alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; to reduce or prevent threats to public health and safety; for health oversight activities such as evaluations, investigations, audits, and inspections; to governmental agencies that monitor your services; for lawsuits and similar proceedings; for public health purposes such as to prevent the spread of a communicable disease; for certain approved research purposes; for law enforcement reasons if required by law or in regards to a crime or suspect; to correctional institutions in regards to inmates; to coroners, medical examiners and funeral directors (for deceased); as required by law; for specialized government functions such as military and veterans activities, national security and intelligence purposes, and protection of the President; for Workers' Compensation purposes; for the management and coordination of public benefits programs; to respond to requests from the U.S.

Department of Health and Human Services; for us to receive assistance from business associates that have signed an agreement requiring them to maintain the confidentiality of your health information; and for the purpose of raising funds to benefit the Board.

If you have a guardian or a power of attorney, we are also permitted to provide information to your guardian or attorney in fact.

Fundraising Activities - We may also use your health information to contact you to raise money as part of fundraising efforts, such as for assistance in passing levies. You have the right to opt-out of receiving such communications by notifying us, at the address below, that you do not wish to be contacted for such purposes**.**

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN PERMISSION

We are prohibited from selling your health information, such as to a company that wants your information in order to contact you about their services, without your written permission.

We are prohibited from using or disclosing your health information for marketing purposes, such as to promote our services, without your written permission.

All other uses and disclosures of your health information not described in this Notice will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written permission. We are unable to take back any disclosures we have already made with your permission.

PROHIBITED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

If we use or disclose your health information for underwriting purposes, we are prohibited from using and disclosing any genetic information in your health information for such purposes.

POTENTIAL IMPACT OF OTHER LAWS

If any state or federal privacy law requires us to provide you with more privacy protections than those described in this Notice, then we must also follow that law in addition to HIPAA. For example, drug and alcohol treatment records generally receive greater protections under federal law.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

- Right to Request Restrictions**.** You have the right to request a restriction or limitation on the health information we use or disclose about you for purposes of treatment, payment, and health care operations and to inform individuals involved in your care about that care or payment for that care. We will consider all requests for restrictions carefully but are not required to agree to any requested restrictions.*
- Right to Request Confidential Communications**.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to Inspect and Copy. You have the right to request access to certain health information we have about you. Under certain circumstances we may deny access to that information such as if the information is the subject of a lawsuit or legal claim or if the release of the information may present a danger to you or someone else. We may charge a reasonable fee to copy information for you.*
- Right to Amend. You have the right to request corrections or additions to certain health information we have about you. You must provide us with your reasons for requesting the change.
- Right to an Accounting of Disclosures. You have the right to request an accounting of the disclosures we make of your health information, except for those related to treatment, payment, our health care operations, and certain other purposes, such as if the information is the subject of a lawsuit or legal claim or if release of the information may present a danger to you or someone else. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Right to a Paper Copy of Notice. You have the right to receive a paper copy of this Notice.
- To exercise any of your rights described in this paragraph, please contact the Board Privacy Officer at the address or phone number listed below:

Privacy Officer
Mahoning County Mental Health and Recovery Board
222 West Federal Street, Suite 201
Youngstown, Ohio 44503
(330) 746-2959

* To exercise rights marked with a star (*), your request must be made in writing. Please contact us if you need assistance with your request.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at the Board Office and on our website at: *http://www.mahoningmhrb.org/wp-content/uploads/2015/03/MCMHB-NPP-1-27-15.pdf*

Each Notice will contain an effective date on the first page in the top center. In addition, each time there is a change to our Notice, we will mail information about the revised Notice and how you can obtain a copy to the last known address we have for you in our plan enrollment file.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Board or with the Secretary of the Department of Health and Human Services. To file a complaint with the Board, contact the Privacy Officer at the address above. We will investigate all complaints and will not retaliate against you for filing a complaint.

HEATH HISTORY QUESTIONAIRE

This form should be completed as fully as possible by client but reviewed by medical staff.

Client Name (First, MI, Last)	DOB	Age

Has the client had any of the following health problems?

	Now	Past	Never	What Treatment Received and Date(s)
Anemia	o	o	o	
Arthritis	o	o	o	
Asthma	o	o	o	
Bleeding Disorder	o	o	o	
Blood Pressure (high or low)	o	o	o	
Bone/Joint Problems	o	o	o	
Cancer	o	o	o	
Cirrhosis/Liver Disease	o	o	o	
Diabetes	o	o	o	
Epilepsy/Seizures	o	o	o	
Eye Disease/Blindness	o	o	o	
Fibromyalgia/Muscle Pain	o	o	o	
Glaucoma	o	o	o	
Headaches	o	o	o	
Head Injury/Brain Tumor	o	o	o	
Hearing Problems/Deafness	o	o	o	
Heart Disease	o	o	o	
Hepatitis/Jaundice	o	o	o	
Kidney Disease	o	o	o	
Lung Disease	o	o	o	
Menstrual Pain	o	o	o	
Oral Health/Dental	o	o	o	
Stomach/Bowel Problems	o	o	o	
Stroke	o	o	o	
Thyroid	o	o	o	
Tuberculosis	o	o	o	
AIDS/HIV	o	o	o	
Sexual Transmitted Disease	o	o	o	
Learning Problems	o	o	o	
Speech Problems	o	o	o	
Anxiety	o	o	o	
Bipolar Disorder	o	o	o	
Depression	o	o	o	
Eating Disorder	o	o	o	
Hyperactivity/ADD	o	o	o	
Schizophrenia	o	o	o	
Sexual Problems	o	o	o	
Sleep Disorder	o	o	o	
Suicide Attempts/Thoughts	o	o	o	
Other:	o	o	o	
Other:	o	o	o	

Please note family history of any of the above conditions and client's relationship to that family member.

Client Name (First, MI, Last)	DOB.
Has client had medical hospitalizations/surgical procedures in the last 3 years? ( ) No ( ) Yes If yes, complete information below.	

Hospital	City	Date	Reason

o None: **Allergies/Drug Sensitivities**

o Food (specify):

o Medicine (specify):

o Other (specify):

Not Pertinent **Pregnancy History**

Currently pregnant? If yes, expected delivery date. ( ) No ( ) Yes	**Receiving pre-natal healthcare? If yes, indicate provider.** ( ) No ( ) Yes
Are you currently breast-feeding? ( ) No ( ) Yes	
Last Menstrual Period Date:	**Any significant pregnancy history? If yes, explain.** ( ) No ( ) Yes

Last Physical Examination

By Whom:	**Date:**	**Phone No. (If Known)**

Has client had any of the following symptoms in the past 60 days? Please check.

o Ankle Swelling	o Coughing	o Lightheadedness	o Penile Discharge	o Urination Difficulty
o Bed-wetting	o Cramps	o Memory Problems	o Pulse Irregularity	o Vaginal Discharge
o Blood in Stool	o Diarrhea	o Mole/Wart Changes	o Seizures	o Vision Changes
o Breathing Difficulty	o Dizziness	o Muscle Weakness	o Shakiness	o Vomiting
o Chest Pain	o Falling	o Nervousness	o Sleep Problems	o Other:
o Confusion	o Gait Unsteadiness	o Nosebleeds	o Sweats (night)	o Other:
o Consciousness Loss	o Hair Change	o Numbness	o Tingling in Arms & Legs	o Other:
o Constipation	o Hearing Loss	o Panic Attacks	o Tremor	o Other:

( ) Not Applicable **Immunizations (required for child or MR/DD only)**

Immunizations – Has client had or been immunized for the following diseases? Please check.

o Chicken pox o Mumps	o Diphtheria o Polio	o German Measles o Small Pox	o Hepatitis B o Tetanus	o Measles o Other:

Immunizations Within the Past Year:

Height/Weight

Height	If reporting for a child, has height changed in the past year? ( ) No ( ) Yes If yes, by how much (+ or -)?
Weight	Has client's weight changed in the past year? ( ) No ( ) Yes If yes, by how much (+ or -)?

Client Name (First, MI, Last)	**DOB:**

Nutritional Screening (please check)

o No Problem	Eating (circle) More Less Not Eating	Drinking (circle) More Less Takes Liquids Only	Appetite (circle) Increased Decreased

( ) Nausea **( )** Vomiting **( )** Trouble Chewing or Swallowing

Special Diet:	**Other:**

Pain Screening

Does pain currently interfere with your activities? If yes, how much does it interfere with these activities (please check)

( ) No ( ) Yes **( )** Not at All **( )** Mildly **( )** Moderately **( )** Severely **( )** Extremely

Please indicate the source of the pain.

Substance Use History/Current Use (please check appropriate columns)

Substance	**No Use**	**Past Use**	**Current Use**	**Substance**	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use
Alcohol/Beer/Wine	o	o	o	**Sleep Medication**	o	o	o	**Cocaine/Crack**	o	o	o
Marijuana	o	o	o	**Tranquilizers**	o	o	o	**Heroin**	o	o	o
Hashish	o	o	o	**Hallucinogens**	o	o	o	**Pain Medication**	o	o	o
Stimulants	o	o	o	**Inhalants**	o	o	o	**Other:**	o	o	o

Caffeine use? If yes, form (coffee, tea, pop, etc.) **( )** No **( )** Yes	How much a week (cups, bottles)?
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) **( )** No **( )** Yes	How much a week (packs, etc.)?

Print Name of Person Completing the Questionnaire	Signature of Person Completing this Questionnaire	Date:

Comments, Recommendations, or Referrals by Medical Reviewer **( ) No Referral Needed**

Check Referral(s) Needed and Specify Action(s)

- o Primary Care Physician: _____
- o Healthcare Agency: _____
- o Specialty Care: _____
- o Other (specify): _____

Recommendations shared with client? If yes, client's response. ( ) No ( ) Yes

Medical Reviewer Signature/Credentials (Nurse, PA, NP, MD, DO)	**Date:**

TRAVCO Behavioral Health
AN AFFILIATE OF FIRST STEP RECOVERY

Authorization to Disclose Information

Name of Client:_____ DOB:_____

The following programs are authorized to: _____ disclose, _____receive, or_____ exchange information as noted below:

Program Authorized to Make Disclosure: **Travco Behavioral Health, Inc.**

Authorized Individual/Organization to Whom Disclosure is Made:

_____
Organization(s)

Purpose of disclosure: _____to coordinate treatment, _____to gather assessment information for treatment planning, _____To gather information for ongoing treatment, ___other, specify:

_____
Other

The type of Information Disclosed: ___ progress notes, ___diagnostic assessment information, ___progress in treatment, ___lab results/testing, ___attendance, ___HIV/Aids testing or status, ___pregnancy testing, ____prenatal care, ____diagnosis, ____information on mental illness and/or treatment, __other, specify:

_____
Other

Amount of information to be disclosed: ____previous three months, ____information covering the most recent admission, ____ other amount of information/specify:

_____
Other

_____ _____
Signature of Client Date

_____ _____
Parent/Guardian Date

_____ _____
Witness/Staff Date

Revocation: This authorization is subject to written revocation at anytime, except to the extent the program or person who is to make the disclosure has already acted in reliance on it. **I hereby revoke my consent in writing:**

_____ _____
Client/Parent/Guardian Date

_____ _____
Witness/Staff Date

This authorization expires (180 days-6 months) _____

Prohibitions against re-disclosure: This information has been disclosed to you from records protected by Federal Confidentiality rules. 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 permits, or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restricting use of this information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient's records are also protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed, and a copy of this authorization will accompany every disclosure.)

TRAVCO Behavioral Health

AN AFFILIATE OF FIRST STEP RECOVERY

Standing Order for Counseling/RN Services
Per Medical Director

Not to exceed 12 months with renewal

Client Name: _____

- Psycho-Education Services
- Urine Analysis
- Vitals
- Interpret Test Results
- Administer Medication
- Medication Education Services

_____ _____

Signature of Ordering Physician Date

Ronald Yendrek D.O.

TRAVCO Behavioral Health

AN AFFILIATE OF FIRST STEP RECOVERY

I, _____ consent to receive text message appointment reminders from Travco Behavioral Health and understand it is my responsibility to update my contact information with the front staff in the event my information changes. If I fail to provide updated information Travco Behavioral Health Inc., is not liable for any messaging that is delivered to the original contact information.

Client Signature: _____Date: _____

Client Cell Phone Number: _____

Witness: _____Date: _____