Chapter 1

Precontact: Referral Forms

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This chapter includes forms to be used to communicate with external sources and clients referred for services. Six forms are included to assist in making the referral process consistent and timely. However, in most cases, external referral sources will have their own processes and forms. You may want to talk with referral sources about possible benefits of providing them with blank forms from your agency.

The pre-contact stage is a brief portion of the process of entering treatment, with the bulk of the paperwork involved in bringing a client into your program taking place in the pretreatment intake and assessment process. These forms are in Chapter Two. The following forms are included in this chapter:

Form 1.1: Referral for Services

Form 1.2: Appointment Notification/Confirmation Letter

Form 1.3: Referral and Treatment Compliance Follow-Up Letter

Form 1.4: Thank You for Your Referral

Form 1.5: HIPAA Notice of Privacy Practices and HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

Form 1.6: HIPAA—Client Sign-In Sheet

Form 1.1 Referral for Services

Client Name: ____________________________ Date of Birth: __________ Date: _____/____/____

Referral Source/Contact: ____

Client Address: ________________________ Client/ SSN #: _________________________________

________________________ Agency Address: _______________________________

Client Phone: (H) ________________________

(W) ______________________ Agency Phone: _____________ Fax: ______________

Parent/Guardian: ________________________ Agency Contact Person: _________________________

Emergency Contact Name/Phone: ____

Preferred Focus of Treatment: ____

____

Service(s)/Program(s) Requested:

( ) Individual counseling ( ) Case management

( ) Family counseling ( ) Psychological testing

( ) Group counseling ( ) Psychiatric assessment

( ) Substance abuse counseling ( ) Medication monitoring

( ) Medical examination ____

( ) Other: ____

Appointment(s) Will Be Scheduled by:

( ) Client ( ) Clinician ( ) Customer service rep. ( ) Other: ____________________

Insurance Information:

No insurance: ___________

Insurance Company: _____ Blue Cross/Blue Shield _____ CHAMPUS/TriCare ___ Medicare
_____ Aetna _____ Cigna _____ Premier _____ Health Partners
_____ Other: ____

Policy #: _________ Enrollment/Plan/Group Number: _________ Effective Date: ____/____/____

Signature of Staff Member Completing Form: _______________________ Date: ____/____/____

Name/Title of Staff Member Completing Form: ____

Individual HIPAA Provider Number of Staff Member Completing Form: ______________________

HIPAA Organization Number of Staff Member Completing Form: _____________________________

Form 1.2 Appointment Notification/Confirmation Letter

Date: _____/_____/_____

Dear: ________________________

You have been referred to, or have chosen to receive services from, our agency. You were referred by: ________. Your first appointment is scheduled for the following date and time:

Date: __/__/__ Day: ___ Time: __ AM/PM

You will be seeing: ______________________________

If you are unable to keep this appointment, please call this agency in advance by calling the following number: _____________________.

- You can expect the first appointment to take approximately ________________, as we will need to complete forms and gather additional information to best serve you. This will also allow time to answer any questions you may have.

- In order to complete this initial appointment in a timely fashion, please bring the following information and/or documentation with you: ____

  ____

  ____

  ____

- This will help us work with you in determining insurance coverage, fees for services, and/or who will be billed.

- The fee for your first visit will be $ ____________. This agency's policy on payment is

  ____

  ____

  However, payment for services is the client's responsibility regardless of what arrangements have been made with other payers.

I look forward to meeting with you!

Sincerely,

Name: ____________________________

Title: ______________________________

Form 1.3 Referral and Treatment Compliance Follow-Up Letter

Date: ____/____/____

To: ________________________

Client Name: ________________________________ Case # / ID #: ________________________

An authorization for disclosure has been signed by the above named client that permits this communication.

Referral/Treatment Status

( ) Client met with our intake worker, clinician, doctor on: ____/____/____.

( ) Client failed to attend screening/intake appointment dated: ____/____/____.

( ) Client is scheduled to attend the following: ______ Individual _____ Marital/Family _____Group counseling/therapy program _____________ starting ______/_____/______.

( ) Client failed to attend his/her scheduled session on _____/__________/_____.

( ) Client has failed to schedule an appointment as of this date.

( ) Client enrolled but failed to complete the following program:____________________________ Reason for failure: ____

( ) Client attended sessions but has not fulfilled financial requirements.

( ) Client completed screening/intake but failed to enroll in the program.

( ) Client was previously noncompliant but is currently attending sessions.

( ) Client satisfactorily completed required sessions and other tasks/activities and received a certificate of completion dated: _____/_____/_____.

( ) Client has been contacted and has declined services at this time (reason(s) given if any): ____

( ) Client has been referred for additional services to: ________________________________

Additional Comments: ____

____

____

____

Signature of Staff Member Completing Form: ________________________ Date: ____/____/____

Name/Title of Staff Member Completing Form: ____

Individual HIPAA Provider Number of Staff Member Completing Form: ______________________

HIPAA Organization Number of Staff Member Completing Form: ____________________________

Form 1.4 Thank You for Your Referral

To: ______________________ Agency/School/Company: ___________________________________

We have processed your referral of ______________________ for services at this program/agency.

Date Referral Received: ______________________

The above named individual has given us permission to acknowledge that he/she has made contact with our agency. If additional correspondence is indicated, we will obtain a HIPAA-compliant Authorization of Disclosure.

Please contact us if you have any additional information that may assist us in providing services. Your referral is important to us!

Signed: _____________________________ Name/Title: _____________________________________

Program/Service: ____________________ Phone: ______________ Fax: ________________________

Individual HIPAA Provider Number of Staff Member Completing Form: ________________________

HIPAA Organization Number of Staff Member Completing Form: ______________________________

Form 1.5 HIPAA 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 this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the medical health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

Your Mental Health and/or Medical Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third-party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of (agency name)

We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except

to the extent that action has already been taken.

- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for name of Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations

(Name of clinic) will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside of the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report serious threat to health or safety of child and/or vulnerable adult.

For payment, if applicable: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For More Information or to Report a Problem

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand (agency name) HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name: ____
Last First MI

Address: ____
Street City State Zip

Date of Birth: ____

Today's Date: ____

For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: ____

______________________________ ______________________________
Clinician Signature Date

Individual HIPAA Provider Number of Clinician Completing Form: ____________________

HIPAA Organization Number of Clinician Completing Form: ____________________

Form 1.6 HIPAA—Client Sign-In Sheet

The page that follows can be reproduced on plain paper or on a full sheet of peel-off labels (Avery Standard 5167 Return Address label form), either by photocopying the following page from this book or by printing the Microsoft Word file titled CH0106.DOC on a laser or inkjet printer. If printed, it will produce an entire 8.5” x 11” sheet of entries.

If the page is reproduced on plain paper, it should be placed on a clipboard, and patients/clients should be instructed to sign in and hand the clipboard to a staff member or notify staff that they have signed in. Staff should then note the patient/client’s arrival on a paper or computerized schedule/calendar that is positioned so as not to be visible to patients/clients, and mark through the patient/client’s initials and time entry with an opaque permanent marker before making the clipboard available to the next patient/client.

If the page is reproduced on a sheet of label forms, patients/clients should again be instructed to sign in and hand the clipboard to a staff member or notify staff that they have signed in. Staff may then peel off the label and stick it on the patient/client’s chart or on a paper schedule/calendar, or use it in any other internal tracking system, again ensuring that it is not visible to other patients/clients, and make the clipboard available to the next patient/client.

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