Personal Information for Families

Age of child _____

Grade _____

Teacher _____

Because I am a remote only clinician I am asking for your home address in case of an emergency when we are meeting.

_____
_____
_____
_____

Because we sometimes have to mail things I am asking for your mailing address if it is different from your home address.

_____
_____
_____
_____

Parent's/Caregiver's legal names:

_____

_____

_____

Parent's/caregiver's phone numbers:

_____

_____

_____

Is there a good time to reach you by phone (preferably during office hours from 8am to 5pm)?

Yes at _____

No, anytime is fine

Informed Consent for Telehealth Services

Lutheran Community Services Northwest (LCSNW) knows that there are times when you or your provider may not be able to engage in face-to-face health care services. We are committed to continuing to serve you during those times through the provision of telehealth services.

Description of Telehealth Services: "Telehealth" refers to services that can either occur over the phone, or "telephone services," and services that can only occur when you and your provider can see each other via video technology and can communicate back and forth in real time, or "telemedicine services."

For all telehealth services (telephone and telemedicine):

1. Your provider will always be in a secure and private location to provide telehealth services. You must also be aware of your surroundings when telehealth services are provided to you. It is your responsibility to choose a location where your conversations with your provider cannot be overheard by others.
2. Standard data and message rates will apply. LCSNW will not reimburse you for the costs of telehealth services.
3. You release LCSNW from all claims, damages, losses, and expenses arising out of your failure to use a secure location and method of communicating with LCSNW while engaging in telehealth services, including but not limited to your use of an unsecure wifi connection.

For telemedicine (video services) only:

4. LCSNW will provide you with a link and a phone number that you can use to join the telemedicine session. LCSNW will send you this information via the email address or text number that you provide below.
5. The video link is a secure method of delivery. In order to maintain the full security of the connection, you need to connect to the session using a phone or using a secure wifi network. This means that the wifi network that you use must require a password that is not publicly available or publicly displayed.

Anticipated Results and Benefits of Telehealth Services: The anticipated results and benefits of telehealth services are to effectively and efficiently assist you with the care, management, and treatment of your health condition(s).

Potential Risks: As with any medical service, there are potential risks associated with the use of telehealth. These risks include, but are not be limited to, delays in treatment due to failures of telehealth software or equipment. Also, security protocols could fail, causing a breach of privacy of your medical information.

Alternatives: Alternatives to telehealth include face-to-face services from a provider or not receiving any treatment. However, providers who may be able to meet face-to-face with you may not have the same expertise as a remote telehealth provider. Additionally, your choice not to receive any treatment could make your health condition(s) worse.

Text and Phone Call Consent: By your signature below, you consent to LCSNW's transmission of calls and unencrypted text messages at the cell number below, and unencrypted email messages at the email address below, related to the telehealth services. Unencrypted communications carry certain risks. For example, text messages and emails could be received by other people who have access to your device. By your signature below, you acknowledge that these risks exist and expressly consent to receive unencrypted communications described in this Consent from LCSNW.

Cell number: _____ **Email address:** _____

By my signature, I, the client designated below, understand the above description of the telehealth services, the potential benefits and risks of telehealth, and the possible treatment alternatives. I certify that I have had the opportunity to ask questions and consent to receiving telehealth services from LCSNW.

Client Name _____

Signature_____ **Date** _____

Name/Relationship of Authorized Signer (if other than client): _____

LUTHERAN COMMUNITY SERVICES CONSENT FOR SERVICES

All persons age 13 or over who will be receiving direct treatment services must sign consent for service. If a child is 12 years or younger, or an adult is dependent, a parent or other legal guardian must sign consent for services. By signing as such, you indicate that you have the legal right to do so.

CONSENT FOR SERVICE

By signing below, I acknowledge receipt of the statement of Consumer Rights and Consumer Grievance Procedures, a copy of the Washington Mental Health Benefits Booklet which addresses information regarding Advanced Directives and Ombuds services, and consent to receive services from Lutheran Community Services Northwest. I understand that others whom I may wish to participate will be considered present for collateral support only.

NOTIFICATION OF PRIMARY CARE PHYSICIAN

In accordance with Early Periodic Screening, Diagnostic and Treatment (EPSDT), which is a federal comprehensive and preventive child health program, I understand it is the practice of Lutheran Community Services to notify a Primary Care Physician when an individual under the age of 21 enters into mental health services. Unless I indicate otherwise, my signature below permits the release of enrollment, diagnosis, and initial medical necessity determination to the physician's office for this specific purpose.

SIGNATURE ON FILE

I authorize Lutheran Community Services Northwest to act as my agent in billing my insurance and/or other third party payors and authorize release of such information they may require to permit payment. I also authorize those payors to make payment directly to Lutheran Community Services Northwest and permit a copy of this authorization to be used in place of the original. I understand that I will be responsible for my own bill and that my estimated portion is due at the time of each service. If I receive services through a medical coupon, I understand that a current coupon must be presented at the first visit of each month.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) CONSENT

I understand that as a condition to my receiving treatment and/or services from Lutheran Community Services Northwest (LCSNW), LCSNW may use or disclose my personally identified health information to provide the treatment and/or services I request, to obtain payment for the treatment/services provided, and as necessary for the operations of LCSNW. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice by contacting the Quality Improvement Director at (509) 747-8224.

I also understand that I have the right to request LCSNW to restrict how my health information is used or disclosed. LCSNW does not have to agree to my request for the restriction, but if LCSNW does agree, LCSNW is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that LCSNW has taken action in reliance on my consent for use or disclosure of my health information. I understand that provision of future treatment may be withdrawn if I withdraw my consent.

Client Signature (must sign if age 13 or older)	Date	Printed Name
Parent/Guardian Signature	Date	Printed Name / Relationship

Signatures/Printed Names of Others Participating in Treatment:

Nancy J LaMusga, MA, LMHC, CCTP
Mental Health Counselor License LH60831361

CLINICIAN QUALIFICATIONS

Nancy J LaMusga received their Masters in the Art of Counseling Psychology degree from Saint Martin's University. Nancy has experience working with children, youth, and young adults through elders, individuals impacted by homelessness and poverty, and marginalized communities. Nancy has participated in training that empowers people to maximize their strengths and move forward in their lives. Nancy continues to expand their learning through conferences, training, online learning and self-study. Nancy has been trained in multiple treatment methods : Trauma Therapies, TF-CBT, Person Centered Therapy, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Multicultural Therapy, Social Constructivist theories, Integrative Therapy, Cognitive Behavioral Therapy + for kids, CPT, and ARC (Attachment, Regulation, and Competency). Nancy is a Certified Clinical Trauma Professional.

TREATMENT METHOD

Nancy J LaMusga enjoys using the client-centered approach to treatment. Nancy believes that the individuals they work with are the experts on their experiences and works with individuals to empower themselves and meet their goals. They use a strength-based approach with clients that helps them identify their own strengths/goals for forward movement. Nancy believes that a safe and supportive environment helps people face challenging and traumatic events from the past or from current experiences. As well as believing that all behavior communicates a need. **For the purposes of the Remote School Based Mental Health Counseling and CLEAR program, Nancy will be using the Attachment, Regulation and Competency (ARC) model.**

BILLING

If a client needs mental health treatment that is outside the scope of the school-based ARC program, they will be referred to appropriate external providers. External providers will have their own billing policies. WSU CLEAR and LCSNW will not be financially responsible for services rendered by external providers.

INFORMATION

The Remote Mental Health Counseling School Program is funded through a SAMHSA grant and there is no charge for you and your child to participate. Appointments will be 30 to 50 minutes in length after the initial intake and assessment appointment. Parent involvement is required during the intake for any child under the age of 13 and throughout the treatment process. ARC recognizes the importance of caregiver involvement for the success of their child and time will be spent with parent(s)/caregiver(s) to provide psychoeducation and skills building on: The Impact of Trauma and Trauma Responses, Development, Attunement, Regulation and Competency. This will allow parent(s)/caregiver(s) to co-regulate and help their child learn to identify their feelings and states of regulation, calm themselves through regulation skills, communicate their needs effectively and strengthen relationships.

PROFESSIONAL CONDUCT AND RIGHT TO CHOOSE AND/OR REFUSE TREATMENT

Clients have the right to choose a counselor and a method of treatment that best suits their needs. This includes the right to refuse treatment. The Counselor Credentialing Act was created to provide protection for public health and safety and to empower clients by Providing a complaint process. We are required to provide a list of the acts of unprofessional conduct as well as the following contact information for the Department of Health:

Health Professions Quality Assurance Customer Service Center,
PO Box 47865, Olympia, WA 98504,
(360) 236-4700.

"Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment." RCW 246-810-031

MANDATORY REPORTING

Mandatory Reporting is required by law and exists for the protection of you, your child(ren), and others who may be at risk of harm. This includes reporting historical information as well as current concerns. As detailed in your Consumer Rights, other circumstances also exist in which information may be released without your consent. For further information regarding these instances, please refer to RCW 71.05.390.

AGREEMENT AND SIGNATURES

Your signature below indicates that you have read, understand and agree to the above, and that you have received a copy of this Disclosure Statement as well as a copy of the Statement of Consumer Rights and the Acts of Unprofessional Conduct as listed in RCW 18.130.180.

Guardian Signature (if not present to sign in Credible)	Date	Client Name & DOB

Lutheran Community Services
NORTHWEST
Health • Justice • Hope

210 West Sprague, Spokane, WA 99201
Phone: (509) 747-8224 Fax: (509) 747-0609

AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

Today's Date: _____

I, _____ Date of Birth _____ hereby give permission to Lutheran Community Services Northwest ("LCSNW") to:

☐ **Disclose information to** ☐ **Receive information from**

Name: _____ **Agency/Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

☐ **Regarding myself** ☐ **Regarding the following children/other dependents in my custody:**

Client name: _____ **Date of Birth:** _____

Client name: _____ **Date of Birth:** _____

☐ **My Entire Record**

☐ **Only the following information:**

Record Department use
☐ *Mail* ☐ *fax* ☐ *call to pick up*
Phone number to call for pickup: _____

☐ Assessment/Diagnosis
☐ Treatment Plan
☐ Mental Health Evaluation/Treatment
☐ Substance Abuse Evaluation
☐ Attendance Records Only
☐ Progress Report of my treatment
☐ Treatment Recommendations

☐ Other (Specify): _____

☐ **Excluding the following information:**

_____

_____

Form in which the information should be released:

☐ Verbal ☐ Written ☐ Other: _____

The purpose of this disclosure is:

☐ To permit continuity of care ☐ To permit case management ☐ Other: _____

I understand that my records may contain protected information regarding diagnosis and/or treatment for HIV (AIDS virus) or other sexually transmitted diseases, drug/alcohol diagnosis and/or treatment, and/or Mental Health diagnosis and/or treatment.

I give consent to release information regarding HIV/AIDS evaluation/treatment. (client's initials) _____.

I give consent to release information regarding drugs/alcohol evaluation/treatment. (client's initials) _____.

I give consent to release information regarding Mental Health evaluation/treatment/medication. (client's initials) _____.

I understand I have the right to receive a copy of this Authorization form. I also understand that upon my written request, LCSNW must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.

I understand that once LCSNW discloses my health information, LCSNW cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this Authorization at any time for any reason; any requests to revoke this Authorization must be in writing. Such as refusal or revocation will not affect the commencement, continuation, or quality of LCSNW's treatment of me, unless my treatment at LCSNW is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization; in such a case, LCSNW may refuse to treat me if I do not sigh this Authorization. LCSNW may also condition the provision of research-related treatment on my provision of an Authorization for the use or disclosure of protected health information for such research.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

****This Authorization expires: _____** ***(Note: If an expiration event is used, the event must relate to the Consumer or the purpose of the use or disclosure.)*** **This authorization expires no later than one (1) year after the date of signature. If no specific expiration date is indicated, then the expiration date will be considered the date one (1) year after the date of signature.**

Client Signature (age 13 & over): _____ Date: _____

Print client's full name: _____ Date of Birth: _____

Parent/Guardian Signature (child under 18): _____ ☐ GAL ☐ DCFS Date: _____

Parent/Guardian Signature (child under 18): _____ ☐ GAL ☐ DCFS Date: _____

Print Parent/Guardian full name: _____

Therapist Name (please print): _____ ☐ Send out ☐ File ☐ Refused to sign

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless 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 alcohol or drug abuse patient.

If there is a fee for this service, please obtain prior approval from the Records Department. Your reply may be sent in care of:

Records Department
Lutheran Community Services
210 West Sprague Ave
Spokane, WA 99201

By signing the designated area below, I am renewing this Authorization to be valid for another one (1) year period through the specified expiration date (which cannot exceed one (1) year from the date of signature).

Consumer/Legal Representative Signature	Date Signed	Expires

Consumer Name: _____ ID #: _____

Lutheran Community Services
NORTHWEST
Health • Justice • Hope

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Name: _____ **Agency/Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

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Client name: _____ **Date of Birth:** _____

Client name: _____ **Date of Birth:** _____

☐ **My Entire Record**

☐ **Only the following information:**

Record Department use
☐ *Mail* ☐ *fax* ☐ *call to pick up*
Phone number to call for pickup: _____

☐ Assessment/Diagnosis
☐ Treatment Plan
☐ Mental Health Evaluation/Treatment
☐ Substance Abuse Evaluation
☐ Attendance Records Only
☐ Progress Report of my treatment
☐ Treatment Recommendations

☐ Other (Specify): _____

☐ **Excluding the following information:**

_____

_____

Form in which the information should be released:

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Parent/Guardian Signature (child under 18): _____ ☐ GAL ☐ DCFS Date: _____

Print Parent/Guardian full name: _____

Therapist Name (please print): _____ ☐ Send out ☐ File ☐ Refused to sign

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Client name: _____ **Date of Birth:** _____

Client name: _____ **Date of Birth:** _____

☐ **My Entire Record**

☐ **Only the following information:**

Record Department use
☐ *Mail* ☐ *fax* ☐ *call to pick up*
Phone number to call for pickup: _____

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☐ Other (Specify): _____

☐ **Excluding the following information:**

_____

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Consumer/Legal Representative Signature	Date Signed	Expires

Consumer Name: _____ ID #: _____

CONSUMER RIGHTS

As a Lutheran Community Services Northwest (LCSNW) Consumer, You Have the Right To:

Receive services that do not discriminate against you and are sensitive to your race, creed, national origin, religion, gender, sexual orientation, language, age, or disability;

Be provided reasonable opportunity to practice the religion of choice, alone and in private, insofar as such religious practice does not infringe on the rights and treatment of others, or the treatment program. The individual has the right to refuse participation in any religious practice;

Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and age or cultural differences. Including a certified language or sign language interpreter, written materials, alternate formats, and accessibility to location consistent with Title VI of the Civil Rights Act.

- You may contact the Office of Civil Rights for more information at http://www.hhs.gov/ocr.

Be treated with respect, dignity and privacy. To have your privacy protected; provided that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises;

Be free of any sexual or physical harassment or exploitation;

Be fully informed regarding amount and duration of services needed, fees charged, methods of payment available, and be free of any financial exploitation;

Confidentiality of clinical and personal information treatment in accord with state and federal regulations as described in chapters 70.02, 71.05, and 71.34 Revised Code of Washington (RCW), except when LCSNW is required by law to notify someone. These possible exceptions include:

- When there is reason to believe a child has been neglected or abused;
- When there is imminent risk of danger to yourself or others;
- When there is reason to believe an elder or disabled adult has been abused;
- When a valid request is received and written authorization by the individual or legal guardian to release designated treatment information is obtained.
- Information submitted to Department of Social and Health Services (DSHS) is also protected by these laws;

The actual law about confidentiality is available for you upon request. You may request a copy of the signed release.

Request and receive a copy of your clinical records, review records in the presence of the administrator of designee, and be given the opportunity to request amendments or corrections to the record;

Request and receive information about the structure, operation, policies, and procedures of the Regional Support Network (RSN) and Community Mental Health Agencies (CMHAs) as they pertain to your rights;

Receive a copy of our complaint and grievance procedures upon request. To lodge a complaint or grievance with LCSNW, Regional Support Network (RSN), Ombudsperson, or DSHS, if you believe the agency has violated your rights or a Washington Administrative Code (WAC) requirement regulating behavioral health agencies;

- If you file a complaint or grievance with LCSNW, the RSN, Ombuds, or DSHS you will be free of any retaliation.
- The Ombuds may, at your request, assist you in filing a grievance. You may reach them at 477-4666.

File an administrative hearing with DSHS without first accessing the contractor's grievance process. Use the DSHS pre-hearing and administrative hearing processes as described in chapter 388-02 WAC;

Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge. Including filing an RSN appeal based on a written Notice of Action;

If you are Medicaid eligible, to receive all services that are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the RSN about what services are medically necessary;

Participate in the development of a plan of care which addresses your unique needs, participate in decisions regarding your mental health care, receive services in a manner that is non-coercive and that protects your right to self-determination, and be informed about the expectations and other factors, including refusal, that can result in discharge or termination of services;

Understand available treatment options/alternatives, request information about local agency's locations, phones, and languages, and refuse any proposed treatment consistent with the requirements in 71.05 and 71.34 RCW;

All consumers, guardians of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available provider staff within the mental health prepaid health plan (PHP);

To change your primary care provider within the first 90 days of enrollment and once during a 12 month period for any reason pursuant to WAC 388-865-0345 (3);

The right to request disenrollment from the PHP pursuant to WAC 388-865-0340 (4);

Not be denied communication with significant others in emergency situations;

Not be subjected by facility staff to physical abuse, corporal punishment, or other forms of abuse administered against their will, including being denied food, clothing, or other basic necessities;

Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects specified in 388-04 WAC;

If the consumer is on a less restrictive alternative court order, the consumer has the right to:

Access attorneys, courts and other legal resources;

Be told statements made by the consumer may be used in the involuntary proceedings;

Be advised of their rights under chapter 71.05 RCW when being detained or committed;

Be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

Any person who leaves a public or private agency following evaluation or treatment for metal disorder shall be given a written statement setting forth the substance of Section 450 RCW 71.05 and 388-865-565.

As an LCSNW Consumer, You Have the Responsibility To:

Respect the rights of other persons at LCSNW, including other clients, staff, and visitors;

Provide relevant information as a basis for receiving service and participating in service decisions;

Ask questions, if there is anything about your treatment services you do not understand;

Not to bring mood altering substances to LCSNW, including illegal drugs and alcohol;

Not bring weapons into the facility;

Be accountable for your actions if you do not abide by city, county, state, and federal laws.

Other Consumer Rights as Stated in the Washington Administrative Code:

LCSNW shall ensure consumers, prospective consumers, and/or legally responsible others are verbally informed, in their primary language, of consumer rights at admission to brief intervention and community support services.

LCSNW shall post a written statement of consumer rights in public areas, with a copy available to consumers on request.

NOTICE OF PRIVACY PRACTICES OF LCSNW
Effective Date*: *June 1, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Lutheran Community Services Northwest (LCSNW) is a hybrid entity under HIPAA. A hybrid entity is an organization in which some programs are covered by HIPAA and some are not. This Notice of Privacy Practices (NPP) and HIPAA requirements only apply to covered programs.

At LCSNW, the Immigration Counseling and Advocacy Program (ICAP) is not covered under HIPAA. ICAP includes the immigration lawyers and staff whose job it is to assist clients with applications to improve immigration status and/or other immigration benefits. All other programs of LCSNW are covered by HIPAA and this NPP.

If you have any questions about this Notice, please contact the Director of Organizational Excellence at 206-816-3209 or hipaa@lcsnw.org.

OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that your health information is personal and we are required by law to protect such information. We are also required to provide you with this Notice, which we must follow, that explains our legal duties and privacy practices.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
Our uses and disclosures of your health information fall into the categories below. We will not use or disclose your health information for any other purposes unless you give us your written authorization to do so. You may revoke an authorization, at any time, in writing, except to the extent that we may have taken an action in reliance on the use or disclosure indicated in the authorization.

A. <u>Uses and Disclosures for Treatment, Payment and Operations.</u>

- **For Treatment.** We may use and disclose your health information for treatment activities. For example, an LCSNW counselor may need to know if you are receiving other services at LCSNW. In addition, we may participate in a Health Information Exchange (HIE) network which helps members of your healthcare team share your health information to serve you better. For example, LCSNW may share or receive your health information from hospitals, laboratories, health care providers, public health departments, health plans or your health insurance.
- **For Payment.** We may use and disclose your health information for payment activities. For example, in order to obtain payment, we may give your health plan information about your care.
- **For Health Care Operations.** We may use and disclose your health information to support our operational activities. For example, we may use health information to evaluate our services.

B. <u>Uses and Disclosures of Your Health Information We May Make Unless You Object.</u>

- **Appointment Reminders.** We may use and disclose health information to contact you as a reminder that you have an appointment for services at LCSNW.
- **Treatment Alternatives.** We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We will obtain your authorization first, if we receive direct or indirect payment from a third party for the communication.
- **Individuals Involved in Your Care.** We may release health information to a person who is involved in your medical care or helps pay for your care unless you restrict such disclosure.
- **In the Event of a Disaster**. In the event of a disaster, we may disclose your health information to assist in relief efforts, coordinate care, and inform your family about your condition and location.
- **Directories**. We may list certain limited information about you, including your name, location in a facility, and your general condition (fair, stable, etc.) in our directory**.**

- **Fundraising Activities**. We may use and disclose some limited types of your health information to contact you in an effort to raise money. Any fundraising materials will contain an opt-out option.

C. Uses and Disclosures We May Make Without Your Authorization.

- **Required By Law.** We will disclose your health information as required by law.
- **Health or Safety.** We may use and disclose your health information to a person who is able to prevent or lessen a serious threat to the health and safety of you or the public.
- **Business Associates.** We may disclose your health information to our business associates that perform functions or services on our behalf.
- **Organ and Tissue Donation.** If you are an organ donor, we may release your health information to organ procurement or transplantation organizations or to an organ donation bank.
- **Military and Veterans**. If you are a member of the armed forces, we may release health information as required by military command authorities.
- **Workers' Compensation.** We may release your health information to workers' compensation or similar programs.
- **Public Health.** We may disclose your health information for public health activities.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency.
- **Lawsuits and Disputes.** We may disclose your health information to answer a court or administrative order, subpoena, discovery request, or other process as permitted by law.
- **Law Enforcement.** We may release your health information to law enforcement as permitted by law.
- **Research**. We may use and disclose your health information for research as permitted by law.
- **Coroners, Medical Examiners and Funeral Directors**. We may release your health information to a coroner, medical examiner, or funeral director as necessary.
- **National Security and Intelligence Activities.** We may release your health information to federal officials as authorized for intelligence and other national security purposes.
- **Protective Services for the President and Others**. We may disclose your health information to authorized officials for the protection of the President and others.
- **Inmates or Individuals in Custody**. If you are an inmate, we may release health information to the appropriate correctional institution or law enforcement official.

D. Uses and Disclosures That Require Your Authorization

- **Psychotherapy Notes**: Most uses and disclosures of psychotherapy notes by your mental health counselor that are kept apart from the rest of your record require your authorization.
- **Marketing and Sale Purposes**: Uses and disclosures for marketing purposes or disclosures that constitute a "sale" of your health information require your authorization.
- **Other Uses and Disclosures.** Uses and disclosures other than those described in this Notice will only be made with your written authorization.

E. Confidentiality of Alcohol and Drug Abuse Patient Records

- If you are admitted into one of our federally assisted alcohol and drug rehabilitation programs ("Programs"), alcohol or drug abuse records about you that we maintain in a Program are protected by Federal law and regulations. Generally, a Program may not say to a person outside the Program that a patient attends the Program, or disclose any information identifying a patient as an alcohol or drug abuser, unless:
    - The patient consents in writing:
    - The disclosure is allowed by a court order; or
    - The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
- Violation of the Federal law and regulations by a Program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.
- Federal law and regulations do not protect any information about a crime committed by a patient either at the Program or against any person who works for the Program or about any threat to commit such a crime.
- Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.
- (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. part 2 for Federal regulations.)

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information for a fee. We may deny inspection and copying in limited circumstances.
- **Right to Amend.** You may ask, in writing, for us to amend your healthcare information kept by LSCNW. We may deny your request for an amendment in certain circumstances.
- **Right to an Accounting of Disclosures.** You have the right to request, in writing, an accounting of our disclosures of your health information.
- **Right to Request Restrictions.** You have the right to request, in writing, a restriction of our use or disclosure of your health information for treatment, payment or health care operations. We are not required to agree to such restriction unless the disclosure is to a health plan for payment or health care operations and pertains solely to an item or service for which you have paid out-of-pocket in full.
- **Right to Request Confidential Communications.** You have the right to request, in writing, that we communicate with you about health matters in a certain way to maintain confidentiality. We will agree to reasonable communication requests.
- **Right to Receive Notification of a Breach.** You have the right to be notified if we discover a breach of your unsecured health information.
- **Right to a Paper Copy of This Notice.** At any time, you have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

CHANGES TO THIS NOTICE:

We reserve the right to change the terms of this Notice at any time. The revised Notice will apply to all of your health information that we maintain. We will provide you with a revised notice upon your visit to LCSNW, through our web site (www.lcsnw.org), or through mail if requested.

Complaints:

If you believe that your privacy rights have been violated, you may register a complaint with us by calling 206-816-3209 and asking for our Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services. The Privacy Officer can provide you with information about filing a complaint. ***You will not be penalized for filing a complaint.***

Child and Adolescent Trauma Screen (CATS) - Caregiver Report (Ages 7-17)

Name: _____ **Age:** _____ **Gender:** _____ **Date:** _____

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen. **Mark YES if it Happened to the child** **Mark NO if it didn't happen to the child.**	
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐Yes ☐No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐Yes ☐No
3. Robbed by threat, force or weapon.	☐Yes ☐No
4. Slapped, punched, or beat up in the family.	☐Yes ☐No
5. Slapped, punched, or beat up by someone not in the family.	☐Yes ☐No
6. Seeing someone in the family get slapped, punched or beat up.	☐Yes ☐No
7. Seeing someone in the community get slapped, punched or beat up.	☐Yes ☐No
8. Someone older touching his/her private parts when they shouldn't.	☐Yes ☐No
9. Someone forcing or pressuring sex, or when he/she couldn't say no.	☐Yes ☐No
10. Someone close to the child dying suddenly or violently.	☐Yes ☐No
11. Attacked stabbed, shot at or hurt badly.	☐Yes ☐No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐Yes ☐No
13. Stressful or scary medical procedure.	☐Yes ☐No
14. Being around war.	☐Yes ☐No
15. Other stressful or scary event Describe:	☐Yes ☐No
Which one is bothering the child most now?	
If you answered NO to all of the above questions, STOP. **If you answered YES to any of the above questions, please complete the rest of this form.**	

Please mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last TWO WEEKS: **0-Never 1-Once in a while 2-Half the time 3-Almost always**	
1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0 1 2 3
2. Bad dreams related to a stressful event.	0 1 2 3
3. Acting, playing or feeling as if a stressful event is happening right now.	0 1 2 3
4. Feeling very emotionally upset when reminded of a stressful event.	0 1 2 3
5. Strong physical reactions when reminding of a stressful event (sweating, heart beating fast)	0 1 2 3
6. Trying not to remember, talk about, or have feelings about a stressful event.	0 1 2 3
7. Avoiding activities, people, places, or things that are reminders of a stressful event.	0 1 2 3
8. Not being able to remember an important part of a stressful event.	0 1 2 3
9. Negative changes in how he/she thinks about self, others or the world after a stressful event	0 1 2 3
10. Thinking a stressful event happened because he/she or someone else did something wrong or did not do enough to stop it.	0 1 2 3
11. Having very negative emotional states (afraid, angry, guilty, ashamed).	0 1 2 3
12. Losing interest in activities he/she enjoyed before a stressful event. Including not playing as much.	0 1 2 3
13. Feeling distant or cut off from people around him/her.	0 1 2 3
14. Not showing or reduced positive feelings (being happy, having loving feelings).	0 1 2 3
15. Being irritable, or having angry outbursts without a good reason and taking it out on other people or things.	0 1 2 3
16. Risky behavior or behavior that could be harmful.	0 1 2 3
17. Being overly alert or on guard.	0 1 2 3
18. Being jumpy or easily startled.	0 1 2 3
19. Problems with concentration.	0 1 2 3
20. Trouble falling or staying asleep.	0 1 2 3
(Clinical = 15+) **TOTAL**	

Please mark YES or NO if the problems interfered with:	
1. Getting along with others	☐ Yes ☐ No
2. Hobbies/ Fun	☐ Yes ☐ No
3. School or work	☐ Yes ☐ No
4. Family relationships	☐ Yes ☐ No
5. General happiness	☐ Yes ☐ No

Child: _____ Child age _____

Caregiver: _____ Date: _____

PSC17 – Completed by Parent/Guardian (for ages 4-17)

INSTRUCTIONS: This form asks question about your child's behaviors. These behaviors may be true for every child at sometime in his or her life. Please read each question carefully and check off the box for the response that you believe is most true for your child during the past **6 MONTHS.**

	Please mark under the heading that best fits your child			*For Office Use*		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Feel sad.	☐	☐	☐			
2. Feel hopeless.	☐	☐	☐			
3. Feel down on him/herself.	☐	☐	☐			
4. Worry a lot.	☐	☐	☐			
5. Seem to be having less fun.	☐	☐	☐			
6. Fidget, is unable to sit still.	☐	☐	☐			
7. Act as if driven by a motor.	☐	☐	☐			
8. Daydream too much.	☐	☐	☐			
9. Distract easily.	☐	☐	☐			
10. Have trouble concentrating.	☐	☐	☐			
11. Fight with other children.	☐	☐	☐			
12. Not listen to rules.	☐	☐	☐			
13. Not understand other people's feelings.	☐	☐	☐			
14. Tease others.	☐	☐	☐			
15. Blame others for his/her troubles.	☐	☐	☐			
16. Refuse to share.	☐	☐	☐			
17. Take things that do not belong to him her.	☐	☐	☐			
TOTAL						

To Score:

Fill in the unshaded box on the right: "Never" = 0, "Sometimes" = 1, "Often" = 2.

Sum the columns.

PSC17-Internalizing score is the sum of column I.

PSC17-Attention is the sum of column A

PSC17-Externalizing is the sum of column E.

PSC-17 Total Score is the sum of PSC17-I + PSC17-A + PSC17-E.

Positive Scores:

PSC17-I	≥ 5
PSC17-A	≥ 7
PSC17-E	≥ 7
Total Score	≥ 15

Adapted for LCSNW Credible BH entry from:
PSC 17 Externalizing Gardner, Lucas, Kolko, & Campo, 2007