Confidential Client Registration Information

Name (First, MI, Last): | Gender: □ M □ F | Birthdate (mm/dd/yyyy):

Street Address: | City: | State: | Zip Code: | County:

Home Phone: | Work Phone: | Cell Phone:

Would you like to receive text message appointment reminders? □ Yes □ No
(By checking yes you are consenting to receive text messages on your cell phone. Text message rates may apply.)

Social Security Number:

Marital Status: □ S □ M □ W □ D

Education Level: □ H.S. Diploma □ GED □ None □ Graduate Degree □ College Degree

Veteran: □ Yes □ No

Are you registered to vote? □ Yes □ Need to update information □ No □ Want to register

How did you hear about us (Referral Source):

Race:
□ American Indian or Alaska Native □ Black or African American
□ Asian □ White/Caucasian
□ Hispanic/Latino □ Other _______________

Ethnic Background:
□ Mexican □ Puerto Rican
□ Cuban □ Dominican Rep
□ Other Hispanic □ Non-Hispanic/Latino

Primary Language Spoken at Home:
□ English □ Sudanese
□ Spanish □ Vietnamese
□ Other ____________________

Emergency Contact Name: | Relationship to Client: | Phone Number:

Have you received previous mental health treatment? □ Yes □ No

If yes, when, where and focus of treatment:

Employment:
□ Full-Time □ Retired
□ Part-Time □ Unemployed
□ Student

Total Annual Household Income:
□ Less than $5,000 □ $5,000 - $9,999
□ $10,000 - $14,999 □ $15,000 - $24,999
□ $25,000 - $34,999 □ $35,000 or more

Number of Dependents: ________

Income Source: □ Employment □ Public Assistance □ Retirement/Pension □ Disability □ None □ Other:

Living Structure:
□ Family Home □ Residential Treatment Center
□ Relative's Home □ Shelter
□ Group Home □ Homeless
□ Living with Others □ Hospital
□ Foster Care Home □ Other ____________________

Service Information

Check which service(s) you would like to receive:
□ Outpatient Counseling □ Medication Management

Why are you seeking our services (check all that apply):
□ Alcohol and/or Drug Use and/or Abuse □ Domestic Violence □ Bipolar
□ Relationship or Marital Problems □ Suicidal Thoughts and/or Attempts □ Anxiety
□ Emotional, Physical and/or Sexual Abuse □ Depression □ Other:

Parent/Legal Guardian Information (**For clients under 19 years of age, elderly, mentally disabled, etc.)**

Parent/Guardian Name (First, MI, Last): | Relationship to Client:

Street Address: | City: | State: | Zip Code:

Home Phone: | Work Phone: | Cell Phone:

Insurance Plan Information

Primary Plan Name:	Policy Number:	Group Number:
Policy Holder's Name:	Birthdate (mm/dd/yyyy):	Social Security Number:
Policy Holder's Employer:		Relationship to Client:
Secondary Plan Name:	Policy Number:	Group Number:
Policy Holder's Name:	Birthdate (mm/dd/yyyy):	Social Security Number:
Policy Holder's Employer:		Relationship to Client:

Are you eligible for SSI?	□ Yes □ No	If yes, are you receiving SSI benefits?	□ Yes □ No
Are you eligible for SSDI?	□ Yes □ No	If yes, are you receiving SSDI benefits?	□ Yes □ No
Are you eligible for Medicaid?	□ Yes □ No	If yes, are you receiving Medicaid benefits?	□ Yes □ No
Are you eligible for Medicare?	□ Yes □ No	If yes, are you receiving Medicare benefits?	□ Yes □ No

*****A copy of your current insurance card is required at the time of service for every appointment.*****

Release to Insurance

My signature authorizes the release of any pertinent information to a third-party payer, if applicable, and assigns benefits to Mid-Plains Center. I understand that payment is required at the time of each visit unless other arrangements have been made in advance. The fee has been explained to me and my signature authorizes Mid-Plains Center to provide services to the person listed as the client. Prompt payment is required and past due accounts are subject to collection.

Client Signature: ____

Parent/Guardian Signature: ____ Date: ______________________

Medical History

How would you describe your physical health?	□ Good	□ Fair	□ Poor
How would you describe your mental health?	□ Good	□ Fair	□ Poor
Do you have problems eating?	□ Too much	□ Not enough	□ No

Current Height: _____Feet ________Inches Current Weight: _______Pounds

Have you had any noticeable weight changes?	□ Gain	□ Loss	□ No
Do you have problems sleeping?	□ Too much	□ Not enough	□ No

Do you have a Primary Care Physician? □ Yes □ No

Name: ____ Phone Number: _________________________________

Have you had a check-up in the last 12 months? □ Yes □ No If yes, date: _________________________________

List Current Medications (prescription and/or over-the-counter):

___

___

___

List any known allergies:

___

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Medical History Continued

Have you been around anyone in the past year who has Tuberculosis?	□ Yes □ No
Have you ever had a positive skin test for Tuberculosis?	□ Yes □ No
Have you ever had a positive HIV test?	□ Yes □ No
Have you ever had a positive Hepatitis B test? If yes, are you interested in any type of referral or follow up care?	□ Yes □ No □ Yes □ No
Have you ever had a positive Hepatitis C test? If yes, are you interested in any type of referral or follow up care?	□ Yes □ No □ Yes □ No
Do you have a Mental Health Board Commitment?	□ Yes □ No

Women: (check all that apply)

□ It is possible that I am pregnant.
□ I am pregnant and use drugs.
□ I am pregnant and use IV drugs.
□ I use drugs and I have dependent children.
□ I use drugs and I am trying to regain custody of my children.
□ None of the above.

Self-Administered Screen for Alcohol and/or other Drugs

During the past 12 months have you stopped smoking cigarettes for one day or longer because you are trying to quit? □ Yes □ No

How long has it been since you last smoked a cigarette, even one or two puffs?
□ within the past 24 hours □ within the past 3 days □ within the past week □ within the past month □ within the past 3 months
□ within the past 6 months □ within the past year □ more than a year ago □ don't know/not sure □ never smoked

Are you aware of the Nebraska Tobacco Quit Line? □ Yes □ No

Have you attempted to use this Line to help you quit? □ Yes □ No

Intake Coordinator will answer this question
Does the client meet diagnostic criteria for Nicotine dependence? □ Yes □ No

1. Have you ever used any alcohol or other drugs? (if no, skip to question 14) □ Yes □ No

Substance Used:	How used: (smoke, oral, IV)	Frequency: (times per month)	Average Amount:	Age: (first use)	Age: (last use)
Alcohol □ Yes □ No		□ Daily □ Weekly □ Monthly			
Tobacco □ Yes □ No	□ Smoke □ Oral	□ Daily □ Weekly □ Monthly			
Marijuana/Hash/Pot/Oil □ Yes □ No	□ Smoke □ Oral □ Vape	□ Daily □ Weekly □ Monthly			
Barbiturate (Luminal, Butison, Fiorinal) □ Yes □ No	□ Oral □ IV	□ Daily □ Weekly □ Monthly			
Crack/Cocaine □ Yes □ No	□ Smoke □ Oral □ IV	□ Daily □ Weekly □ Monthly			
Heroin □ Yes □ No	□ Smoke □ Oral □ IV	□ Daily □ Weekly □ Monthly			
Methamphetamine □ Yes □ No	□ Smoke □ Oral □ IV	□ Daily □ Weekly □ Monthly			
Hallucinogen (LSD/ Mushrooms) □ Yes □ No	□ Smoke □ Oral	□ Daily □ Weekly □ Monthly			
Painkillers (Hydrocodone, Oxycodone, Fentanyl) □ Yes □ No	□ Oral □ Other	□ Daily □ Weekly □ Monthly			
Inhalants (glue/gas) □ Yes □ No		□ Daily □ Weekly □ Monthly			
Benzodiazepine (Valium, Xanax, Ativan) □ Yes □ No	□ Oral □ Other	□ Daily □ Weekly □ Monthly			
Other:	□ Smoke □ Oral □ IV	□ Daily □ Weekly □ Monthly			

2. Have you ever felt you've used too much alcohol or other drugs? □ Yes □ No

3. Have you ever tried to cut down or quit using alcohol or other drugs? □ Yes □ No

4. Have you ever gone for help because of your drinking or other drug use? □ Yes □ No
(such as: AA, NA, other counselors or a treatment program)

If yes, how many have you attended in the past 30 days? _______

Self-Administered Screen for Alcohol and/or other Drugs Continued

5. Have you ever had any health problems from alcohol or other drugs? □ Yes □ No

6. Have you ever: (check all that apply)
   - □ Had blackouts or other periods of memory loss?
   - □ Injured yourself after drinking or using other drugs?
   - □ Had convulsions or delirium tremens (DT's)?
   - □ Felt sick, shaky or depressed when you stopped using?
   - □ Felt "coke bugs" or a crawling feeling under your skin after you stopped using?
   - □ Used needles to inject other drugs?
   - □ None of the above.

7. Has your drinking or other drug use ever caused problems at school or work? □ Yes □ No

8. Have you ever been arrested due to alcohol or other drugs? □ Yes □ No If yes, in the past 30 days? □ Yes □ No

9. Have you ever lost your temper, gotten into arguments or fights while drinking or using other drugs? □ Yes □ No

10. Do you ever need to drink more alcohol or use more other drugs to get the effect you want? □ Yes □ No

11. Do you spend a lot of time thinking about how to get alcohol or other drugs? □ Yes □ No

12. When drinking or using other drugs, are you more likely to do something you wouldn't normally do? □ Yes □ No
   (Such as: break the law, sell possessions that are important to you or have unprotected sex)

13. Do you feel bad or guilty about your drinking or other drug use? □ Yes □ No

14. Have any of your family members ever had a drinking or other drug problem? □ Yes □ No

   If yes, who: ____

Your therapist will complete this section.

Items 1 and 14 are not scored. The following items are scored as 1 (yes) 0 (no):

___ 2	___ 5	___ 8	___ 11	
___ 3	___ 6	___ 9	___ 12	
___ 4	___ 7	___ 10	___ 13	___ Total Score (score range 0-12)

Score		Degree of Risk for AOD Abuse (Preliminary Interpretation of Responses)			
0-1	none to low	2-3	Minimal	4 & >	Moderate to high, possible need for further assessment

Consent for Treatment

I hereby consent to health care treatment provided by Mid-Plains Center. This includes assessment and treatment procedures, as appropriate. I understand that treatment options will be discussed with me and I have a right to participate in decisions about my treatment.

Client Name: ____

Client Signature: ____

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: ________________________________

Cancellation and No Show Policy

In an effort to continue providing responsive and quality care to our community, Mid-Plains Center requires the cancellation of any appointment to occur at least 24-hours in advance.

Office appointments cancelled with less than a 24-hour notice may be subject to a $25 cancellation fee. This fee is the responsibility of the individual and is required to be paid in full prior to the next scheduled appointment.

Individuals who miss their scheduled appointments, without prior notification, will be considered a "No Show." Two (2) or more "No Shows" in a three (3) month period may result in the termination of services and/or the denial of future appointments; in these instances, the cancellation fee will apply.

Region 3 Behavioral Health Services

Eligibility Worksheet for Nebraska Behavioral Health Services Funded Services

An initial Eligibility Worksheet must be completed at admission or as soon as possible after admission and must be completed annually thereafter. You may not bill the Region or DHHS for any services for this consumer until Financial Eligibility has been established. The worksheet does not need to be completed for services listed on the Emergency Access Services Fee Schedule.

Client Name: ____

Are you covered by any of the following? (must check one)

□ Private Insurance □ Affordable Care Act (aka Obamacare) □ Medicaid □ Medicare □ Other ______________________ □ None

Will filing the insurance claim pose a risk to you? (domestic violence, child abuse or other danger occurring) □ Yes□ No

Does the above coverage pay for this service? □ Yes□ No

Taxable Monthly Income _______________

Annual Income __________________ (can be computed by dividing annual income by 12)

Less Monthly Total Allowable Liabilities:

Housing: Monthly rent/lease/mortgage amount, not to exceed $535 per month (Limited to the home or apartment the consumer currently occupies) _______________

Utilities: For the house/apartment reflected above, if the utilities are not included in the rent/lease:
Monthly utilities, not to exceed $469 per month _______________
OR
For the house/apartment reflected above, if only a portion of utilities are included in the rent/lease amount:
Monthly utilities, not to exceed $245 per month _______________
(Utilities refers to heating & cooking fuel, air conditioning, septic tank, water, sewage, trash & basic telephone only)

Transportation: Car payment and average gasoline cost or cost of public Transportation, not to exceed $250 per month _______________

Daycare: $200 for each child age one or younger (Number of children ____ x $200) _______________

(if paying a 3rd party) $175 for each child age two or older (Number of children ____ x $175) _______________

Total Allowable Liabilities: $_______________

Adjusted Monthly Income to be used to determine Eligibility: $_______________
(Taxable Monthly Income Less Monthly Total Allowable Liabilities)

Total number of family members dependent on taxable income: _______
(client + spouse (if applicable) + # of children (if applicable))

Copayment Amount: $____________

By signing this form, I am verifying the above amounts are correct to the best of my knowledge.

____

Client Signature Date

Note: You may be asked to supply documents for verification of income and liabilities claimed.

____

Staff Person Signature Date

For Agency Use Only: 20% of Adjusted Monthly Income = $ _____________
(20% is reference for maximum monthly Hardship Copay Only)

Consumer is eligible for Hardship Fee Schedule due to:

______ SPMI
______ SED
______ Medical Bills or Medical Debt in excess of 10% of the taxable annual income
(Taxable Monthly Income x 12 x 10%)

As of January 26, 2018 for use in SFY19

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, check one of the following and attest to your response by providing your name and signing and dating this form.

□ I am a citizen of the United States.

— OR —

□ I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status is ______________________, my alien number is________________________ and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME: ____

(first, middle, last)

SIGNATURE: ____

DATE: _________________________________

To be completed by Intake Coordinator

Self-Observation of Disability

□ Developmental Disability/Retardation	□ Blindness or Severe Visual Impairment	□ Non-Use/Ambulation
□ Non-Ambulation or Major Difficulties in Ambulation	□ Deafness or Severe Hearing Loss	□ No Observable Handicap/Impairment

Trauma History:

Have you ever experienced sexual abuse?	□ Adult □ Child □ N/A
Have you ever been sexually assaulted and/or raped?	□ Adult □ Child □ N/A
Have you ever been involved with prostitution and/or sex trafficking?	□ Adult □ Child □ N/A
Have you ever experienced physical abuse?	□ Adult □ Child □ N/A
Have you ever been physically assaulted?	□ Adult □ Child □ N/A
Have you ever experienced emotional abuse?	□ Adult □ Child □ N/A
Have you ever been neglected?	□ Adult □ Child □ N/A
Have you ever witnessed domestic abuse?	□ Adult □ Child □ N/A
Have you ever been a victim and/or witnessed community violence?	□ Adult □ Child □ N/A
Have you ever been a victim of a crime?	□ Adult □ Child □ N/A
Have you ever been involved in a serious accident and/or suffered a serious injury?	□ Adult □ Child □ N/A
Have you ever had a life threatening medical issue?	□ Adult □ Child □ N/A
Have you ever experienced a traumatic loss?	□ Adult □ Child □ N/A
Have you ever been a victim of a terrorist act?	□ Adult □ Child □ N/A
Have you ever experienced war/political violence and/or torture?	□ Adult □ Child □ N/A
Have you ever experienced a disaster (tornado/earthquake)?	□ Adult □ Child □ N/A
Have you ever experienced sanctuary trauma (trauma while institutionalized)?	□ Adult □ Child □ N/A

Initial Screening for Self-Harm Potential

Was there a potentially lethal suicide attempt in the past 24 hours?	□ Yes □ No
Are there statements of intent to self-harm?	□ Yes □ No
Is there a plan for self-harm?	□ Yes □ No
Is the client unwilling and unable to agree NOT to self-harm?	□ Yes □ No
Is the client experiencing auditory hallucinations that command self-harm?	□ Yes □ No
Is the client an EPC admission? If yes, mark reason below: □ Both dangerous to self & others □ Danger to others □ Danger to self/suicide attempt □ Danger to self/neglect	□ Yes □ No

A "YES" on any of the above questions indicates the need for crisis intervention.

Employee Name: ____

Employee Signature: ___________________________________ Date: ________________________________

(Client accepted at Triage by: ____________________________ Date: ______________________)

Minor Child Information

Is the youth's parent/guardian receiving case management from Health & Human Services? □ Yes □ No
Is the youth and/or family involved with the Juvenile Courts? □ Yes □ No
Is the youth and/or family receiving services voluntarily without court involvement? □ Yes □ No
Is the youth involved with Juvenile Services? □ Yes □ No If yes, check all that apply. □ Drug Court □ OJS State Ward □ Probation □ Other Court Involvement
In the past 3 months, how many days of school did the youth miss? □ 1 day per wk. □ 2 or more days per wk. □ 1 day every 2 wks. □ 1 or less days per month □ Home Schooled □ Not Enrolled
Does the youth's parent/guardian believe our services will affect school attendance? □ Greater Attendance □ Less Attendance □ About the Same □ Does Not Apply – Other □ Does Not Apply – Expelled □ Does Not Apply – Dropped out □ Does Not Apply – Too young □ Does Not Apply – Home Schooled □ Does Not Apply – No problem prior to service □ Unknown
Is the youth receiving Professional Partner Services? □ Yes □ No
Is the youth receiving Special Education Services? □ Yes □ No
What is the youth's living arrangement? □ Emancipated □ Guardian(s) □ Parent(s) □ Ward of the State

Admission Information

Legal Status at Admission: □ Voluntary □ Voluntary by Parent/Guardian □ Parole □ Probation □ MHB Hold/Custody Warrant □ MHB Commit □ Court Order □ Sex Offender □ Emergency Protective Custody □ Court: Competency Evaluation □ Court: Presentence Evaluation □ Not Responsible for Reason of Insanity □ Court: Juvenile Evaluation □ Juvenile High Risk Offender
Reason for Admission: □ Primary Mental Health □ Primary Substance Abuse □ Dual Diagnosis/Primary MH/Primary SA □ Primary Sex Offender □ Primary MH/Secondary SA □ Primary SA/Secondary MH

Medical Treatment Waiver

In response to the results of my mental health intake screening on __________________, I decline to complete the suggested risk assessment.
(Date)

Client Name: ____

Client Signature: ______________________________________Date: ______________

Employee Name: ____

Employee Signature: ____________________________________ Date: ______________

Witness Name: ____

Witness Signature: ______________________________________Date: ______________

***** Present form to client, only if applicable. *****

Telehealth Service Consent

I agree to receive my outpatient behavioral health services through Telehealth. I understand the behavioral health care provider is located in a different location.

□ Yes □ No

I understand that my visit with a practitioner is at a distant site using special audiovisual equipment. Mid-Plains Center's Telehealth Service uses a secure web-based system for transmitting audio and visual data.

I also understand the following:

- The same confidentiality protections that apply to my other behavioral health care, also apply to the Telehealth appointment.
- I will have access to all behavioral health treatment information resulting from the Telehealth appointment, as provided by law and according to the existing confidentiality policy.
- I will be informed of all people who will be present during my appointment and I may exclude anyone during my Telehealth appointment.
- If an emergency arises, I have the option to see a practitioner in-person.

Client Name: ____

Client Signature: ____

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: __________________________

***** Present form to client, only if applicable. *****

Mid-Plains Center for Behavioral Healthcare Services, Inc.

Mid-Plains Center protects the legal and ethical rights of all clients by informing clients of their rights and responsibilities, providing fair and equitable treatment and providing clients with sufficient information to make an informed choice about using our services. No person shall be denied impartial access to treatment or accommodations that are available and medically indicated on the basis of such conditions as age, race, color, creed, national origin or inability to pay for care.

Client Rights:

- To know the identity and professional status of individuals providing your services.
- To request accommodations.
- To know who is responsible for authorizing further assessments and referrals for other treatment.
- To have consistent enforcement of program rules and expectations
- To participate in all decisions regarding treatment planning and to request a review of this plan.
- To have services that promote respect, healing and positive behavior to prevent the need for crisis interventions. Mid-Plains Center prohibits the use of any type of physical restraint.
  - Mid-Plains Center does not support or tolerate acts of domestic violence perpetrated by or against any clients. Mid-Plains Center does not tolerate any acts of domestic violence perpetrated by clients on any employees; this includes the display of any violent or threatening behavior by a perpetrator (verbal or physical) that is likely to result in physical or emotional injury or otherwise places a client or staff's safety at risk.
- To refuse service, treatment or medication, unless mandated by the court/law. With such refusal, to be informed of the consequences, which can include discharge of services.
- To have access to treatment records.
  - You may inspect much of the treatment information we maintain about you, with some exceptions.
  - Upon request, we will release your treatment information to another person. Your signed, written direction needs to clearly designate the recipient and location for delivery.
- To receive a schedule of fees (upon request), estimated or actual cost of services and to be informed prior to service about:
  - Charges for service
  - When co-payments are charged, refunded, waived or reduced
  - Due date of payments
  - The consequence of non-payment
- To request a change of service provider. The first step in this process is to inform the current service provider, IN PERSON, that you wish to change to another service provider. If you experience difficulties or are unsatisfied with the response given by the current provider, you may take the matter up with the service provider's supervisor (inquire at the front desk).
- To request that we amend certain treatment information that we keep in your records. We are not required to make all request amendments, but will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.
- To request that we communicate with you about your treatment information in a certain way or at a certain location. We must agree to your request if it is reasonable and specifies the alternate means or location.
- We are required by law to notify you of a breach of your unsecured treatment information. We will provide such notification to you without unreasonable delay but in no case later than 60 days after we discover the breach.
- Parents/guardians of a minor child you have the following rights:
  - To receive information needed to give necessary consent for the child's treatment and participate in developing their care plan to the extent permitted by law.
  - To refuse treatment to the extent permitted by law and how this refusal may affect the child's condition.
- Treatment of a minor child without parental/guardian consent is as follows:
  - Like most other forms of medical treatment, Nebraska law does not provide any statutory exceptions which allow a minor to consent to mental health and/or substance abuse treatment without parental consent. Therefore, a mental health professional may only render treatment to a minor without consent when another exception is present (the minor is married, emancipated or it is an emergency situation).
- To be informed on how to file a grievance and to receive help in filing the grievance.

If you feel your rights have not been respected or have questions or concerns, please talk to the practitioner or the practitioner's supervisor.

If you continue to feel your concerns have not been adequately addressed or heard, please contact the Client Advocate, Carla Dominick, at 308-385-5250 ext. 1004.

Client Responsibilities:

- To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health and family.
- To make it known whether or not you clearly comprehend the treatment plan and what is expected of you.
- To follow the treatment recommended by the practitioner responsible for your care.
- To inform the practitioner if you are unsatisfied with the care received.
- To share the responsibility with Mid-Plains Center and its staff for your treatment and/or your child's treatment and care. This includes following the plan of care agreed upon, which may recommend medication or behavioral changes.
- To be responsible for your actions if you refuse treatment or do not follow recommendations.
- To provide prompt payment for services.
- To be considerate of facility personnel and property.
- To be responsible for personal belongings brought into the clinic.
- To respect the rights, privacy and confidentiality of others.
- Parents/guardians of a minor child have the following responsibilities:
    - To provide complete and accurate information about your child's health.
    - To be available to the practitioner for consultation and decision-making.
    - To ask questions to understand the diagnosis, treatment, counseling, psychotherapy or instruction.
    - To inform the practitioner if you are unsatisfied with your child's care received.

Grievance Procedure

If you disagree with treatment decisions or practices and procedures, you have the right to file a complaint. You have the right to file a grievance without interference or retaliation. If you believe you have been treated unethically or illegally, you are encouraged to follow the Grievance Procedure below.

- You should first attempt to resolve the grievance informally, by talking to the staff member or the staff member's supervisor.
- If you are not satisfied, you should write a brief statement about the problem and submit it to the Client Advocate. The Client Advocate will respond to the written statement within two (2) weeks. If you are admitted into the Crisis Stabilization Unit, the response time will be two (2) business days. The Client Advocate will attempt to resolve the issue informally by meeting with you and the staff member involved within thirty (30) days. Written summary of resolution will be sent to you, the staff member involved and the President and CEO of Mid-Plains Center.
    - At least one level of review will be conducted that does not involve the person you have a complaint about or the person who reached the decision under review.
- If you are still not satisfied, you may request a formal meeting with the President and CEO. You will receive a written response on the final decision within two (2) weeks.

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Notice of Privacy Practices

Mid-Plains Center is required by law to maintain the privacy of your information and provide you with notice of our legal duties, privacy practices and your rights with respect to your information. Your information includes your individually identifiable medical, insurance, demographic and payment information. For example, it includes information about your diagnosis, medications, insurance status and policy number, claim history, address and social security number.

Uses and Disclosures of Information without your Authorization

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The following are the types of uses and disclosures we may make of your health care information without your permission. Where State or Federal Law restricts one of the described uses or disclosures, we follow the requirements of such State or Federal Law. These are general descriptions only. They do not cover every example of disclosure within a category.

Treatment. We will use and disclose your information for treatment. For example, we will share health care information about you with those involved with your treatment plan.

Payment. We will use and disclose your information for payment purposes. For example, we will use your information to prepare your bill and we will send information to your insurance company with your bill if needed and/or requested.

Treatment Plan. We will use and disclose your information for treatment planning. For example, we will provide other qualified practitioners, within Mid-Plains Center, with your information if several plans are developed.

Appointment Reminders. We may contact you as a reminder of your upcoming appointment.

Family, Friends or Others. We may disclose your general condition to a family member, your personal representative or another person identified by you. If any of these individuals are involved in your care or payment for care, we may also disclose such treatment information as it is directly relevant to their involvement. We will only release this information if you agree, are given the opportunity to object and do not, or if in our professional judgement, it would be in your best interest to allow the person to receive the information or act on your behalf. For example, we may allow a family member to pick up your prescriptions. We may also disclose your information to an entity assisting in disaster relief efforts so that your family or individual responsible for your care may be notified of your location and condition.

Required by Law. We will use and disclose your information as required by Federal, State or Local Law.

Public Health Activities. We may disclose treatment information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability;
- To appropriate authorities authorized to receive reports of child abuse and neglect;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- With parent/guardian permission, to send proof of required medication to a school.

Workers' Compensation. We may release treatment information about you as authorized by law for workers' compensation or similar programs that provide benefits for work-related treatment needs.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. For example, we may use your name to call you from waiting areas. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Other Uses and Disclosures. Other uses and disclosures of your treatment information not covered above will be made only with your written permission. If you authorize us to use and disclose your information, you may revoke that authorization at any time. Such revocation will not affect any action we have taken in reliance on your authorization.

Uses and Disclosures of Information with your Authorization

There are many uses and disclosures we will make only with your written authorization. These include:

Uses and Disclosures Not Described Above. We will obtain your authorization for any use of disclosure of your treatment information that is not described in the preceding examples.

Psychotherapy Notes. We will obtain your authorization for any notes from treatment sessions. Many uses or disclosures of psychotherapy notes require your authorization.

If you provide authorization, you may revoke it at any time by giving us notice in accordance with our authorization policy and the instructions on our authorization form. Your revocation will not be effective for uses and disclosures made in reliance on your prior authorization.

Individual Rights

Access to Treatment Information. You may inspect and copy much of the treatment information we maintain about you, with some exceptions. If we maintain the treatment information electronically in one or more designated record sets and you ask for an electronic copy, we will provide the information to you in the form and format you request, if it is readily producible. If we cannot readily produce the record in the form and format you request, we will produce it in another readable electronic form we both agree to. We may charge a cost-based fee for producing copies or, if you request one, a summary. If you direct us to transmit your treatment information to another person, we will do so, provided your signed, written direction clearly designates the recipient and location for delivery.

Amendment. You may request that we amend certain treatment information that we keep in your records. We are not required to make all request amendments, but will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

Notification in the Case of Breach. We are required by law to notify you of a breach of your unsecured treatment information. We will provide such notification to you without unreasonable delay but in no case later than 60 days after we discover the breach.

Confidential Communications. You may request that we communicate with you about your treatment information in a certain way or at a certain location. We must agree to your request if it is reasonable and specifies the alternate means or location.

How to Exercise These Rights. All requests to exercise these rights must be in writing. We will respond to your request on a timely basis and in accordance with our written policies and as required by law. Contact the Client Advocate at 308-385-5250 ext. 1004, Mid-Plains Center, 914 Baumann Drive, Grand Island, Ne 68803 for more information or to obtain request forms.

Mid-Plains Center for Behavioral Healthcare Services, Inc.

Achieving Excellence in Behavioral Healthcare!

ACCREDITED BY COA COUNCIL ON ACCREDITATION FOUNDED 1977

About this Notice

We are required to follow the terms of the Notice currently in effect. We reserve the right to change our practices and the terms of this Notice and to make the new practices and Notice provisions effective for all treatment information that we maintain. Before we make such changes effective, we will make available the revised Notice by posting it at the Front Desk where copies will also be available. You are entitled to receive this Notice in written form. Please contact Mid-Plains Center at the address listed below to obtain a written copy.

Complaints

If you have concerns about any of our privacy practices or believe that your privacy rights have been violated, you may file a complaint using the contact information at the end of this Notice.

Contact Information

Mid-Plains Center for Behavioral Healthcare Services, Inc.
Attn: Client Advocate
914 Baumann Drive
P.O. Box 1763
Grand Island, NE 68802

Copies of the Client Rights & Responsibilities, Grievance Procedure and Privacy Policy are available upon request. My signature below acknowledges I have been offered copies of them.

Client Name	Parent/Guardian Name
Client or Parent/Guardian Signature (19 & Under)	Date
MPC Staff Name & Signature	Date