NOTICE OF PRIVACY PRACTICES

Adolescent Alternatives

WE ARE REQUIRED BY LAW
TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about health care we provide to you or payment for health care provided to you. It may also be information about your past, present, or future physical or health.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area
- Have copies of the new Notice available upon request (you may always contact the office (336) 370-9876

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you..
- Explain your rights with respect to medical information about you
- Describe how and where you may file a privacy-related complaint

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our office at (336) 370-9876.

Effective Date 04 /AA

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients everyday. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact office (336) 370-9876.

1. Treatment

We may use and disclose health information about you to provide health care treatment to you. In other words, we may use and disclose health information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

2. Payment

We may use and disclose health information about you to obtain payment for health care services that you received. This means that, within AA, we may use health information about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose mental information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose health information about you to an insurance plan before you receive certain health care services because, for example, we may want to know whether the insurance plan will pay for a particular service.

3. Health care operations

We may use and disclose health information about you in performing a variety of business activities that we call "health care operations." These "health care operations" activities allow us to, for example, improve the quality of care we provide and reduce health care costs. For example, we may use or disclose medical information about you in performing the following activities:

Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.
Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills.
Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.
Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
Improving health care and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
Planning for our organization's future operations.
Resolving grievances within our organization.
Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

• • • • • • • • Effective Date

4. Persons involved in your care
We may disclose health information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our office at (336) 370-9876.

We may also use or disclose health information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we mayor may not be able to agree to your request.

5. Required by law
We will use and disclose health information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National priority uses and disclosures
When permitted by law, we may use or disclose health information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose information that it is acceptable to disclose medical information without the individual's permission We will only disclose information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Office at (336) 370-9876.

. **Threat to health or safety** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
. **Public health activities**: We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
. **Abuse, neglect or domestic violence**: We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
. **Health oversight activities**: We may disclose medical information about you to a health oversight agency - which is basically an agency responsible for overseeing the health care system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
. **Court proceedings**: We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if ajudge orders us to do so.
Law enforcement: We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
. **Coroners and others**: We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.

Adolescent Alternatives	Section:
Effective Date: 07/01/2008	Revised Date: 7/5/14

Critical Incidents

POLICY:

INCIDENT DOCUMENTATION

1. Service Record Documentation:

   AA shall develop and implement policy regarding documentation of minor & critical incidents, unusual occurrences and medication errors.

   It is the policy of AA to include the requirement that all incidents including unauthorized possession of weapons, wandering, elopement and other unusual circumstances shall be recorded in the service record including, but not limited to:

   a. a description of the event;
   b. actions taken on behalf of the consumer; and
   c. the consumer's condition following the event.

   Opinions, conclusions or personnel actions relative to an event shall not be included in the record entry.

2. Administrative Requirements:

   AA will develop an administrative system of maintaining information on special or critical incidents. When an incident report is completed which includes the administrative review of the incident, (e.g. cause of incident, suggestions to prevent future occurrence of similar incidents, etc.) the report shall not be referenced or filed in the service record but filed in administrative files.

AA will have an administrative system of maintaining/filing incident reports. The incident reports will be filed in a separate folder by the month and name of the consumers.

AA Executive Director and/or designee will ensure that the Area Mental Health Consumer Rights Coordinator and the Case Coordinator are notified verbally within 24 hours of a major incident, and in writing within 72 hours.

AA will use follow LME/County Program's Incident Reporting protocol and complete/submit its required form for minor and critical incidents within its designated timeframes.

Governing Body
Policy No. 0201

Physical Evaluation

Record#_____

History

Date___/___/___

Name_____Sex__Age__Date of Birth___Personal Physician_____
Address_____Parents Name_____Phone#_____
Emergency Contact_____Phone#_____
School_____Grade_____Sports_____

Explain "Yes" answer below:

	Yes	No
1. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
2. Are you presently taking any medications or pills?	☐	☐
3. Do you have any allergies (medicine, bees, or other stinging insects?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you tire more quickly than your friends during exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you ever been told that you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
5. Do you have any skin problems (itching, rashes, acne)?	☐	☐
6. Have you ever had a head injury?	☐	☐
Have you ever been knocked out or unconscious?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
7. Have you ever had a heat or muscle cramp?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
8. Do you have trouble breathing or do you cough during or after activity?	☐	☐
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?	☐	☐
10. Have you had any problems with your eyes or vision?	☐	☐
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	☐	☐
☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Hip ☐ Forearm ☐ Shin/Calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hand ☐ Foot		
12. Have you ever had an eating disorder, or any concerns about your eating habits or weight?	☐	☐
13. Do you have any chronic medical illness (diabetes, asthma, kidney problems, etc)?	☐	☐
14. Have you had a medical problem or injury since your last evaluation?	☐	☐

15. When was your last tetanus shot?_____
When was your last measles immunization?_____

WOMEN

16. When was your first menstrual period?_____
When was your last menstrual period?_____
What was the longest time between your period last year?_____
Explain "Yes" answers_____

_____

_____

I hereby state, that to the best of my knowledge, my answer to the above questions are correct.
Date____/____/____Signature of Child/Adolescent_____
Signature of Parent/Guardian_____
Date____/____/____

Note to Parents: The sports/screening exam does not substitute for needed regular exams with your child's physician. Follow up immunizations; health screening and guidance are important. A copy of this exam will be forwarded to the physician designated above.

Physical Evaluation

Record#_____

Pre-participation Physical Evaluation (continued)

Physical Examination

Name_____Age_____Date of Birth___/___/___

Height_____Weight_____BP_____/_____Pulse_____

Vision R20/_____L 20/_____Corrected: Y N

GENERAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Heent			
Pulses			
Heart			
Lungs			
Tanner Stage	**1 2**	**3 4 5**	
Skin			
Abdominal			
Genitalia (Males)			
Hernia (Males)			
	MUSCULOSKETAL		
Neck/Back			
Shoulder			
Elbow			
Wrist/Hand			
Knee			
Hip			
Ankle/Foot			

**Clearance:

☐ A. Cleared

☐ B. Cleared after completing evaluation/rehabilitation for: _____

☐ C. NOT cleared for: ☐Collision ☐Contact ☐Manual Physical Restraint

☐Non-contact _____Strenuous_____Moderately Strenuous

_____Non-Strenuous

Due to: _____

Recommendation: _____

_____

_____

Name of Physician_____Address_____Phone_____

Signature of Physician_____Date_____/_____/_____

**(The following are considered disqualifying until medical and parental releases are obtained: acute Infections, obvious growth retardation, diabetes, Down's syndrome, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle, or ovary,

Adolescent Alternatives

CLIENT:	RECORD NO.

Medical Agreement

I understand that my son/daughter will have routine doctor/dentist appointments. I give Adolescent Alternatives consent to transport my son/daughter to all appointments necessary for the benefit of my child. I agree to be responsible for any cost involved or that has incurred in securing these service. I will furnish directly to a physician or hospital documentation financial information utilized computation of fees.

I give permission to take my son/daughter to _____ Hospital or other medical facilities selected by Adolescent Alternatives for emergency medical attention.

X _____ _____

Parent/Guardian Date

_____ _____

Witness Signature/Title Date

Adolescent Alternatives

CLIENT: **RECORD NO.**

Medication Administration Consent Form

The parent/legal guardian of _____gives my consent and authorization for administration of medication in Adolescent Alternatives program as prescribed by a physician.

X _____ _____
Parent/Guardian Date

_____ _____
Witness Signature/Title Date

I, _____, the physician of _____
Recommend that is medically safe for_____ medications to be given that are non-prescription drugs. I have advised patient of the side effects, reactions effectiveness, etc. (If any) of these medication listed below.

_____
_____
_____

_____ _____
Physician Signature Date

CLIENT: RECORD NO.

Emergency Information

The person to be contacted in the event of an emergency shall complete the following information.

Name of Contact Person _____ Relationship to Client _____

Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Work Number/Pager Number _____

Name and location of preferred hospital _____

Name and location of Client's Physician _____

Phone # of Physician _____

TRANSPORTATION POLICY

Adolescent Alternatives have my permission to transport _____
to any medical, recreational, educational, or other activities that are required based upon the PCP plan and the continuation of care.

✕ Guardian Signature:

Staff Signature:

North Carolina Division Mental Health, Mental Retardation, Substance Abuse Services

DISCHARGE SUMMARY/AFTERCARE PLAN

ADOLESCENT ALTERNATIVES

LIENT NAME: _____

)RD NUMBER: _____

HDATE: _____

DMISSION DATE: _____

TO BE COMPLETED WITHIN ? DAY: OF EXPECTED DISCHARGE

( ) Service Closed Date_____

( ) Record Closed Date_____

( ) Administrative Closing Date_____

EASON FOR ADMISSION: _____

EASON FOR DISCHARGE: **(Always document the summary of events or outcomes of eval/tx on progress note & submit to lient record-DO NOT "REFER" TO THIS FORM)**

_____ 1. Evaluation Complete and no additional service is indicated
_____ 2. Treatment Complete
_____ 3. Client not available (moved out of county or currently institutionalized OR incarcerated for more than six months)
_____ 4. Refuses/Declines/Withdraws Consent for Treatment (client, legally responsible person and/or family)
_____ 5. Death
_____ 6. No Show

)ATE OF LAST CONTACT_____

)ISPOSITION AT LAST CONTACT _____

:INAL DIAGNOSIS (Axis I, II, III,) and MEDS/DOSAGES)

_____

_____

AFTERCARE PLAN, if indicated, including recommended services, agency and/or contact person(s) and #'s

Plan: _____

Service(s): _____

Date Effective: _____

Contact Agency/Person #:

)ISCHARGE LIVING ARRANGEMENTS (please check one)

___Adult Care Home –6 or Fewer Beds (Family Care Home)
__Community ICF-MR
_____Private Residence (House, Apartment, Mobile Home, Child Living with Family)
_____Other Independent (Rooming House, Dormitory, Barracks, Fraternity House, Work Bunk House, Ship)
_____Homeless (Street, Vehicle, Shelter for Homeless)
_____Correctional Facility (Prison, Jail. Training School, Detention Center)
_____Institution (Psychiatric Hospital, Mental Retardation Center, Wright, Whittaker)
_____Residential Facility, Excluding Nursing Home (Halfway House, Group Home, Child Care Institution, DDA Group Home)
_____Foster Family, Alternative Family Living
_____Nursing Home (ICF, SNF)
_____Adult Care Home –7 or More Beds (Rest Home)
Other

I have participated in the above discharge/aftercare plan.

_____ _____

Client **Date** **Legally Responsible Person** **Date**

_____ _____

Coordinator of Discharge **Date** **Psychiatrist** **Date**

*FOLLOW-UP (Contact person/Agency/Services) @30 Days

_____Client in Service

_____Client NOT in Service and Why: _____

_____

*FOLLOW-UP (Client/Legally Responsible Party) @30 Days

_____Client in Service & Satisfied with Service

_____Client in Service & NOT Satisfied with Service

_____Client NOT in Service and Why:_____

_____

Follow-Up Recommendations:

Health and Safety Orientation for Consumers

1) The use of restraints and Seclusion (We do not use these practices, only use restraints if the consumer is a clear and present danger to himself or others)

2) Use of Tobacco Products (No use of tobacco Products at facility)

3) Illegal substances brought in (Not permitted at Program)

4) Prescription Medication brought to program (Medication will only be given with current and appropriate order from doctor)

5) Weapons (No weapons are allowed at Facility)

Orientation completed by :_____ Date:_____

Adolescent Alternatives
Discharge Form

Client Name:_____ Record Number:_____

Medicaid #:_____ Admission Date:_____

Discharge Date:_____

Client's Strengths: _____ Needs: _____
Client's Preferences: _____ Abilities: _____
Status of client at last contact: _____
Achievement's while in program:_____
_____
_____

Reason For Discharge

No longer able to meet clients needs _____
Client has met all treatment plan goals _____
Funding no longer available ____
Consent to provide services withdrawn ____
Other _____

Who initiated Discharge?

Client/Guardian _____
AA Decision ____
Treatment Team Decision___

Referred to

No referral _____
LME _____
Another Provider Agency _____
Other _____

Comments upon contacting client after discharge(within 3 days):

_____
_____
_____

AA Representative: _____ Date: _____

Adolescent Alternatives

Consent for Release of Client Information

Re: _____ **Record Number:** _____
(Last Name, First Name)

_____ **Date of Birth:** _____
(Middle & Maiden Name)

I hereby authorize_____ to release specified information
Regarding my treatment to: Adolescent Alternatives 2207 Long Brook Drive, Greensboro, NC 27406

I hereby authorize Adolescent Alternatives to release specified information regarding my treatment to:

_____

Information to be released

_____

This data shall include only that of the nature and to the extent which is specified below:

____ Reason for referral

____ History of Psychotropic Drug Use

____ Psychiatric

____ School Academic Achievement and Behavior

____ Psychological

____ Current Medications

____ HIV/AIDS information

____ Medical Information

____ Legal History

____ Current Medication

____ Substance Abuse/Use/Treatment

____ Social

____ Legal History

Other information: _____

I understand this information will be used for the following purpose: _____

_____

The doctrine of informed consent has been explained to me, and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorize information. I hereby acknowledge that this consent will expire if one of the following three conditions arise further acknowledge that I may revoke this content at any time.

- ☐ One year from this date _____
- ☐ Event _____
- ☐ Condition _____

Guardian/Parent Signature: _____ Date: _____

Staff Signature: _____ Date:_____