wesley family services

CONSUMER INFORMATION PACKET

OUR MISSION

TO EMPOWER CHILDREN, ADULTS, AND FAMILIES BY PROVIDING TRANSFORMATIONAL CARE.

OUR VISION

TO DO MORE FOR MORE CHILDREN, FAMILIES AND ADULTS; BE MORE EFFECTIVE, EFFICIENT AND SUSTAINABLE; AND CONTINUE TO INNOVATE IN WHAT WE DO AND HOW WE DO IT.

OUR VALUES

TRANSFORMATION
EMPATHY
EXCELLENCES
INNOVATION
INSPIRATION

wesley family services

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***Only WFS South Locations as applicable.*

MH OP SUPPLEMENTAL FORMS

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Non-Discrimination

- Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age or sex.
- Personnel policies, procedures, and practices are designed to prohibit discrimination on the basis of race, color, religious creed, disability, ancestry, national origin, age or sex.
- Employment opportunities are available for qualified disabled applicants and reasonable accommodations are made to meet the physical or mental limitations of qualified applicants or employees.
- Any person receiving services or an employee who believes that he or she has been discriminated against may file a complaint of discrimination with any of the following:

Quality and Compliance Office
Wesley Family Services-RIDC Admin
615 Alpha Drive
Pittsburgh, PA 15238

PA Human Relations Commission
11th Floor, State Office Building
300 Liberty Avenue
Pittsburgh, PA 15222

Bureau of Civil Rights Compliance
Department of Public Welfare
Room 512, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

Allegheny County BHDS
Wood Street Commons
304 Wood Street, Suite 500
Pittsburgh, PA 15222

Beaver County BHDS
2nd Floor
1040 Eighth Avenue
Beaver Falls, PA 15010

Butler County BHDS
2nd floor, County Government Building
124 West Diamond Street
Butler, PA 16003

Washington County BHDS
Courthouse Square
100 West Beau Street, Suite 302
Washington, PA 15301

Westmoreland County BHDS
Courthouse Square Extension
40 North Pennsylvania Ave.
Greensburg, PA 15601

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CLIENT RIGHTS AND RESPONSIBILITIES

The following are the rights and responsibilities of all persons served by Wesley Family Services (WFS)

Rights:

1. The Right to be Treated with Respect and Dignity

a. to have access to services based on your individual needs, service criteria and availability
b. to be involved in the development of your service plan, including discharge
c. to receive services in the least restrictive environment
d. to receive services in a safe and sanitary environment
e. to understand any reasons for denial of services

2. The Right to Privacy and Confidentiality

a. to have all communications regarding your services and all personal identifying information treated in a confidential manner consistent with HIPAA and all current federal and state laws

3. The Right to Communicate, to File a Grievance and Appeal

a. to make complaints or suggestions about the services you receive
b. to receive a written copy of the Grievance Policy and Procedures applicable to the program or service you are receiving
c. to appeal a decision if it is determined that services will terminate
d. to have legal assistance if needed, with referral information for legal services provided by program staff

4. The Right to Religious Freedom

a. to practice your religion or to refrain from religious practice
b. to refuse treatment, including medication, if this interferes with your religious beliefs
c. to follow the dietary requirements of your religion, unless it would be a danger to your health as determined by a qualified medical opinion

5. The Right to Treatment or Services

a. to know the cost or fee for services if applicable and to be informed of the hours when services are available
b. to choose service providers, if you have not been court ordered to a service at WFS
c. to participate in developing and reviewing the individualized service plan and to have a copy made available to you
d. to safe physical management as explained in the policy on Behavior Support and Management
e. to refuse treatment session observation by techniques such as one-way mirrors, video or tape recorders, television or photographs
f. to be informed of the behavioral expectations and/or other factors that could result in termination of your services

g. to make the decision about participating in any research project, after the potential benefits and risks have been fully explained to you. Refusal to participate shall not affect the services that you are receiving
h. to have access to written and oral communication that enables understanding and/or compensates for hearing, visual, auditory or language limitations

Responsibilities of Individuals Being Served:

1. to exercise your rights in a mature and responsible manner
2. to provide all necessary information at the time of Intake so that a decision about requested service can be decided
3. to participate actively in your service or treatment plan and through discharge
4. to maintain confidentiality regarding the service provided to others'
5. to respect the rights of others in the service setting
6. to inform staff of any harmful situations that you may become aware of during the course of services
7. to communicate openly and honestly with staff about your concerns and/or about previous services you may have received
8. to learn the rules and regulations of your program or service
9. to respect the property of others
10. to keep your appointments or to cancel in advance so that your appointments can be rescheduled
11. to inform WFS if you decide to stop treatment, withdraw from your program, or change providers
12. to inform staff of any insurance change that may impact the payment for services that you are receiving to have payment available at the time of service for all fees that are not covered by your insurance provider. These may include but are not limited to co-pays, co-insurance, deductibles and rent (if applicable)

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SERVICE RECIPIENT COMPLIANT AND GRIEVANCE RESOLUTION PROCEDURES

If you have a grievance with Wesley Family Services (WFS), the program/service, and/or a therapist, please follow these procedures. Note, any time in the process of resolving the compliant, Wesley Family Service will also support an individual's right in contacting their county, state, and managed care authorities.

1. Bring the grievance to the attention of your assigned program therapist in an attempt to resolve the grievance.

Primary Therapist and telephone number: _____
Secondary Therapist and telephone number: _____

2. If the grievance remains unresolved, please bring the grievance to the attention of the program supervisor verbally or in writing. Upon notification of the grievance, the supervisor will review the grievance with you within seven (7) working days in an effort to resolve the grievance.

A. Supervisor and telephone number: _____

3. If the individual or family remains dissatisfied and the grievance remains unsolved, the supervisor/director will advise the individual receiving services of his/her right to file a complaint electronically or notifying the WFS Quality Department.

- Electronic Notification – The supervisor/director will guide the compliance to the NAVEX location the WFS internet homepage (wfspa.org), strongly suggesting that the individual disclose full name.
- Direct Contact with Quality Department – The supervisor/director will assist the individual in making direct contact with Quality staff person or call 888-399-4024 to provide quality staff. A written compliant can also be submitted on the Service Recipient Compliant Resolution Form.

Quality management staff will acknowledge either the NAVEX or written/called-in complaint and initiate a review of the concern with three (3) working days of receipt of complaint.

4. If the grievance/dissatisfaction with services remains for the individual, he or she will be provided with information about where their complaint may be heard external to the organization (county, state, managed care organizations). At this level of complaint, the appropriate phone numbers and addresses will be provided.

When a formal complaint is filed involving Health Insurance Portability and Accountability Act (HIPAA) and/or privacy matters, the WFS HIPAA Privacy or Security Officer will be notified and a copy of the concern and resolution will be forwarded to them.

WESLEY FAMILY SERVICES

NOTICE OF PRIVACY PRACTICES
Effective May 1, 2018

THIS NOTICE DESCRIBES HOW MENTAL, BEHAVIORAL, MEDICAL, AND OTHER HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a set of federal laws designed to safeguard your health information. These Privacy laws serve several purposes. For example, they establish how your health information can be used by us—your health care provider. They also identify instances when your permission is required to disclose your health information to other persons. Additionally, they identify your rights, and our rights, when it comes to the handling of your health information. PER HIPAA, WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.

• • •

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. Protected Health Information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We will protect the privacy of the health information that we maintain that identifies you, whether it deals with the provision or payment of your health care. We are legally required to follow the privacy practices that are described in this Notice, which is currently in effect.

We reserve the right to change the terms of this Notice and our privacy practices at any time. Any changes will apply to any of your health information that we already have. Before we make an important change to our policies, we will promptly change this Notice and post a new Notice at your location of service. You may also request, at any time, a copy of our Notice of Privacy Practices that is in effect at any given time, from our Quality office at [412-342-2300]. You may view and obtain an electronic copy of this Notice on our web site at [www.fswpa.org].

At Wesley Family Services (WFS), we are committed to protecting the privacy of our patient's mental and physical health information, as the federal and state laws require. This Notice explains how we will satisfy this commitment and your rights about what is in your WFS health record. When we use the terms "information," we are referring to patient health, treatment, or payment information that identifies you, as a WFS patient. All staff and locations that make up WFS must follow this Notice. If you have any questions as a WFS patient, please ask a WFS staff member for more information.

Your PHI is confidential. We are required to maintain the confidentiality of your PHI by the following federal and Pennsylvania laws:

- **The Health Insurance Portability and Accountability Act of 1996.** The Department of Health and Human Services issued the following regulations: "Standards for Privacy of Individually Identifiable Health Information." We call these regulations the "HIPAA Privacy Regulations." We may not use or disclose your PHI except as required or permitted by the HIPAA Privacy Regulations. The HIPAA Privacy Regulations require us to comply with Pennsylvania laws that are more stringent and provide greater protection for your PHI.

- **Pennsylvania Mental Health Confidentiality Laws.** For individuals who receive treatment and services in our mental health programs, Pennsylvania laws may provide additional protection for your PHI. We will comply with any Pennsylvania laws that are more stringent than the HIPAA Privacy Regulations and provide greater protection for your PHI.

- **Confidentiality of Drug and Alcohol Treatment Records.** For individuals who receive treatment and services in our drug or alcohol substance abuse rehabilitation programs, federal and Pennsylvania laws may provide additional privacy protection for your PHI. We will comply with any federal and Pennsylvania laws that are more stringent than the HIPAA Privacy Regulations and provide greater protection for your PHI.

- **Confidentiality of HIV-Related Information.** Pennsylvania laws may provide additional privacy protection for PHI related to HIV. We will comply with any Pennsylvania laws that are more stringent than the HIPAA Privacy Regulations and provide greater protection for your PHI.

We must provide you with this Notice about our privacy practices. It explains how, when and why we may use and disclose your health information. With some exceptions, we will avoid using or disclosing any more of your health information than is necessary to accomplish the purpose of the use or disclosure. If this health information concerns mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and/or HIV status, we may be very limited in what we provide and may be required to first obtain from you specific authorization. Additionally, we will comply with Pennsylvania laws governing who may make decisions related to health information in the case of a minor patient or client.

Following are answers to some common questions concerning our privacy practices:

QUESTION: HOW WILL THIS ORGANIZATION USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION?

Answer: We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

A. Uses and Disclosures Relating to Treatment, Payment or Healthcare Operations. With the possible exception of information concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and HIV status (for which we may need your specific authorization**),** we may by federal law, use and disclose your health information for the following reasons:

1. **For Treatment.** We may disclose your general treatment information to other providers who are involved in your care. For example, we may disclose your treatment history to a hospital if you need medical attention while at our facility or to a residential program we are referring you to. Reasons for such a disclosure maybe to get them the historical treatment information they need to coordinate your care, appropriately treat your condition, or schedule needed testing.

2. **To Obtain Payment for Treatment.** We may use and disclose necessary health information in order to bill and collect payment for the treatment that we have provided to you. For example, we may provide certain portions of your health information to your health insurance company, Medicare or Medicaid, or to the county or a county funded service coordination unit in order to get paid for your treatment.

3. **For Health Care Operations.** We may, at times, need to use and disclose your health information to run our organization. For example, we may use your health information to evaluate the quality of the treatment that our staff has provided to you. We may also need to provide some of your health information to our accountants, attorneys, and consultants in order to make sure that we are complying with the law.

B. Certain Other Uses and Disclosures are Permitted by Federal Law. With the possible exception of information concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and HIV status (for which we may need your specific authorization), we may use and disclose your health information without your authorization for the following reasons:

1. **When a Disclosure is Required by Law.** For example, we may disclose your protected information if we are ordered by a court, or if a law requires that we report that sort of information to a government agency or law enforcement authorities, such as in the case of a dog bite, suspected child abuse, or a gunshot wound.

2. **For Public Health Activities.** Under the law, we need to report information about certain diseases, and about any deaths, to government agencies that collect that information. We are also permitted to provide some health information to the coroner or a funeral director, if necessary, after a client's death.

3. **For Health Oversight Activities.** For example, we will need to provide your health information if requested to do so by the County and/or the State when they oversee the program in which you receive care. We will also need to provide information to government agencies that have the right to inspect our offices and/or investigate healthcare practices.

4. **For Organ Donation.** If one of our clients wished to make an eye, organ or tissue donation after their death, we may disclose certain necessary health information to assist the appropriate organ procurement organization.

5. **For Research Purposes.** In certain limited circumstances for example, approved by an appropriate (Privacy Board or Institutional Review Board under federal law), we may be permitted to use or provide protected health information for a research study.

6. **To Avoid Harm.** If one of our service providers, counselors, physicians, or nurses believes that it is necessary to protect you, or to protect another person or the public as a whole, we may provide protected health information to the police or others who may be able to prevent or lessen the possible harm.

7. **For Specific Government Functions:** We may disclose the health information of military personnel or veterans here required by U.S. military authorizations. Similarly, we may also disclose a client's health information for national security purposes, such as assisting in the investigation of suspected terrorists who may be a threat to our nation.

8. **For Workers' Compensation.** We may provide your health information as described under the workers' compensation law, if your condition was the result of a workplace injury for which you are seeking workers' compensation.

9. **Appointment Reminders and Health-Related Benefits or Services.** Unless you tell us that you would prefer not to receive them, we may use or disclose your information to provide you with appointment reminders or give you information about helpful alternative programs and treatments.

10. **Disclosure to Business Associates.** We may share your information with business associates who perform services on our behalf. The business associate must agree in writing to protect the confidentiality of the information.

11. **Fundraising Activities.** For example, if our organization choose to raise funds to support one or more of our programs or facilities, we may use the information that we have about you to contact you. If you do not wish to be contacted as part of any fundraising activities, please contact your program director.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to Family, Friends or Others Involved in Your Care.** We may provide a limited amount of your health information to a family member, friend or other person known to be involved in your care or in the payment for your care, unless you tell us not to. For example, if a family member comes with you to your appointment and you allow them to come into the room with you, we may disclose otherwise protected health information to them during the appointment, unless you tell us not to.

2. **Disclosures to Notify a Family Member, Friend or Other Selected Person.** When you first start in our program, we ask that you provide us with an emergency contact person in case something should happen to you while you are at our facilities. Unless you tell us otherwise, we will disclose certain limited health information about you (your general condition, location, etc.) to your emergency contact or another available family member, should you need to be admitted to the hospital, for example.

3. **Disaster Relief.** We may use or disclose information to a public or private entity by law to assist with and coordinate disaster relief efforts.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In situations other than those categories of uses and disclosures mentioned above, or those disclosures otherwise permitted under state or federal law, we will ask for your written authorization before using or disclosing any of your protected health information. If you choose to sign an authorization to disclose any of your health information, you can later revoke it to stop further uses and disclosures to the extent that we haven't already taken action relying on the authorization, so long as it is revoked in writing.

QUESTION: WHAT RIGHTS DO I HAVE CONCERNING MY PROTECTED HEALTH INFORMATION?

Answer: You have the following rights with respect to your protected health information:

A. **The Right to Request Limits on Uses and Disclosures of Your Health Information.** You have the right to ask us to limit how we use and disclose your health information. We will certainly consider your request, but you should know that we are not required to agree to it. If we do agree to your request, we will put the limits in writing and will abide by them, except in the case of an emergency. . A WFS patient or their representative has the right to request, and we are required to grant, that the PHI not be disclosed to a health plan (*i.e.*, insurance company) for payment or treatment when the service that is to be excluded from the disclosure was paid for out-of-pocket in full by the patient or person on the patient's behalf.

B. **The Right to Choose How We Send Health Information to You or How We Contact You.** You have the right to ask that we contact you at an alternate address or telephone

number (for example, sending information to your work address instead of your home address) or by alternate means—for example, by (e-mail/mail) instead of telephone. We must agree to your request so long as we can easily do so. Your request must be made in writing.

C. **The Right to See or to Obtain a Copy of Your Protected Health Information.** In most cases, you have the right to look at or get a copy of your health information that we have and use to make decisions about your care. This includes your right to request a copy of your electronic medical record in electronic form. Your request must be in writing. Request forms are available at the reception desk or ask your WFS service provider. We will respond to you within 30 days after receiving your written request. If we do not have the health information that you are requesting, but we know who does, we will tell you how to get it. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial. In certain circumstances, you may have a right to appeal the decision. If you request a copy of any portion of your protected health information, we may charge you, only as allowed under applicable law. We may need to require that payment be made in full before we will provide the copy to you. If you agree in advance, we may be able to provide you with a summary or an explanation of your records instead. There may be a charge for the preparation of the summary or explanation.

D. **The Right to Receive a List of Certain Disclosures of Your Health Information That We Have Made.** You have the right to get a list of certain types of disclosures that we have made of your health information. You also have the right to receive an accounting of disclosure from our business associates. This list would not include uses of disclosures for treatment, payment or healthcare operations, and disclosures to you or with your written authorization, or disclosures to your family for notification purposes or due to their involvement in your care. This list also would not include any disclosures made for national security purposes, or disclosures to corrections or law enforcement authorities if you were in custody at the time. You may not request an accounting for more than a six year period. To make such a request, we require that you do so in writing. A request form is available upon asking at our reception desk or from your WFS service provider. We will respond to you within 60 days of receiving your request. The list that you may receive will include the date of the disclosure, the person or organization that received the information (with their address, if available), a brief description of the information disclosed, and a brief reason for the disclosure. We will provide such a list to you at no charge; but, if you make more than one request in the same calendar year, you will be charged a reasonable fee for each additional request that year.

E. **The Right to Ask to Correct or Update Your Health Information.** If you believe that there is a mistake in your health information or that a piece of important information is missing, you have a right to ask that we make an appropriate change to your information, as long as the information is maintained by or for WFS. This does not permit you to alter or change the original record created by your health care provider or their staff. You must make the request in writing, with the reason for you request, on a request form that is available at the reception desk or from your WFS service provider. We will respond within 60 days of receiving your request. If we approve your request, we will make the

change to your health information, tell you when we have done so, and will tell others that need to know about the change. We may deny your request if the protected health information: (1) is correct and complete; (2) was not created by us; (3) is not allowed to be disclosed to you; or (4) is not part of our records. Our written denial will state the reasons that your request was denied and explain your right to file a written statement of disagreement with the denial.

F. **The Right to Information Regarding Disclosures.** You have the right to ask for an accounting of disclosures of where WFS disclosed your PHI in the six years prior to the date of your request, who we shared it with, and why. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as the ones you asked us to make). We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another within twelve months.

G. **The Right to Be Notified Following a Breach of Unsecured Protected Health Information.** If there is a breach of your protected health information we will send you information about your rights and our obligations related to the breach of your unprotected information.

H. **The Right to get a Paper Copy of This Notice.** If you have received this Notice electronically, you have the right to a paper copy of this Notice.

QUESTION: HOW DO I COMPLAIN OR ASK QUESTIONS ABOUT THIS ORGANIZATION'S PRIVACY PRACTICES?

In the event that a breach of your PHI occurs by WFS or one of its business associates, you will be provided with written notification as required by law.

If you believe your privacy has been violated by us, you may file a complaint directly with us. If you have any questions about anything discussed in this Notice, or about any of our privacy practices, or if you have any concerns please contact the WFS Privacy Officer at412-342-2300. You also have the right to file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We may not take any retaliatory action against you if you lodge any type of complaint.

Wesley Family Services
Privacy Officer
615 Alpha Drive
Pittsburgh, PA 15238

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices. The Notice explains how we may use and/or disclose your health information. Please sign this form to acknowledge your receipt of the Notice. Please note that you may refuse to sign this acknowledgement.

I, acknowledge that I have received a copy of this Notice of Privacy Practices.

_____

Printed Name _____

_____

Signature Date

_____

Co-Signature (Parent Guardian if consumer is age 14-17) Date

This Notice took effect on May 1, 2018.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy however it could not be obtained due to:

- ❑ Refusal by Consumer
- ❑ We Could Not Contact this Consumer
- ❑ Other Details (Please provide details)
  Ex: An Emergency situation prevented us from obtaining acknowledgement.

_____

_____

_____

_____

_____ _____

Employee Signature Date

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ATTENDANCE PROCEDURE ACKNOWLEDGEMENT

PART 1: NOTICE

One important factor in your ability to be successful in treatment is keeping your scheduled appointments with your treating professional. Since treatment attendance is so closely related to treatment success, the Outpatient Department of Wesley Family Services has a procedure about attendance and treatment.

It is the expectation of the agency that any individual being served in our programs keep their scheduled appointments and arrive on time for their appointments. Should you need to cancel or reschedule an appointment, please be advised of the following:

- **If you are going to cancel an appointment, you must do so at least 24 hours in advance of the scheduled appointment. If you do not cancel within at least 24 hours or if you simply do not come, we will consider that you "no showed" your appointment.**
- **If you arrive later than 15 minutes from your schedule appointment time, your treating professional may decide to reschedule your appointment for another time.**
- **After your intake appointment, you will be scheduled for follow up appointment(s) as appropriate. If you do not attend your first follow up appointment and you (or your child) have a first time appointment scheduled with our psychiatrist, that appointment will be cancelled.**

PART 2: ATTENDANCE REVIEW

Your treating professional will be reviewing and discussing your attendance on an ongoing basis and will work with you to develop a plan to improve your attendance as needed.

- **If you are attending outpatient therapy and have two (2) back-to-back no show appointments or three (3) no show appointments in a 90 day treatment period, we are going to consider your attendance to be problematic.**
- **If you are attending intensive outpatient therapy and have three (3) back-to-back no show appointments (a missed appointment with your psychiatrist is counted), we are going to consider your attendance to be problematic.**

At this point, your therapist will develop a plan with you that can include a referral to a Treatment Readiness Group, a Treatment/Attendance Contract, alternative scheduling, suspension of services, or case closure.

PART 3: ACKNOWLEDGEMENT

If you have any questions about this Notice and Acknowledgement, please see one of our staff. Wesley Family Services believes that active participation in treatment is an important part of helping you to achieve your recovery goals. Our goal is to support you in those efforts.

I acknowledge receipt and understanding of the above written notice and agree to abide by the terms of the agency's procedure pertaining to attendance at scheduled appointments.

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OUTPATIENT CRISIS SUPPORTS

If you are experiencing a mental health crisis, please call your county emergency number listed below or go to the nearest emergency room.

Emergency Medical / Psychiatric Services	
Allegheny County – UPMC re:solve Crisis Network	1-888-796-8226
Armstrong County	1-877-333-2470
Butler County	1-800-292-3866
Indiana Open Door	1-877-333-2470
Washington County SPHS Crisis	1-877-225-3567
Westmoreland County MH Crisis Intervention	1-800-836-6010
Any location-	9-1-1

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COLLABORATION OF CARE WITH PCP

Wesley Family Services strives to provide the highest quality service at all times. Studies show it is important to coordinate medical care so that each practitioner is providing care that is the best possible. We are asking you to sign an authorization to release your treatment information to your Primary Care Physician (PCP) so that he or she is aware of your treatment here. All of the insurance companies with which we partner include coordination with your PCP as a part of their best practice guidelines.

Your PCP has to be aware of any medications you might be taking as prescribed by us. Medication interactions are always a concern. The physicians will want to be sure that the medications that are prescribed are not going to interfere with each other.

If you or your child is receiving outpatient therapy, it is important that the PCP or pediatrician be aware of that therapy and the status of that treatment. Sometimes behavioral health symptoms can be confused with physical health symptoms or mask a physical health problem. Therefore coordination of care with the primary care physician is important for you or your child's health.

I have read the above statement and I:

___ Permit Wesley Family Services to communicate with my PCP. (Release Required)

___ Do not wish to sign a release of information to have my treatment information disclosed to my PCP or my child's pediatrician.

___ Do not have a PCP at this time. I will be given resources on how to obtain a PCP.

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Signature Date

If you are able, please tell us why you are not willing to disclose your information to your PCP. This will help us understand your concerns better and plan for your needs.

_____

wesley family services

ANNUAL WELLNESS EXAMINATION OUTREACH

Date:

_____
_____
_____

RE: _____
DOB: _____
DATE: _____

To Whom It May Concern,

We are writing to inform you that the individual listed above is receiving outpatient treatment with Wesley Family Services.

Wesley Family Services programs are designed to transform through effectively collaborating with other service providers, family, and community supports to deliver the right care at the right time. We are requesting information from you to help us connect their physical health and mental health needs to ensure whole health care.

Included is a signed consent from the patient in order to collaborate with you. Please provide our agency with the date of the individual's wellness visit and/or the results of their most recent blood work. We look forward to the opportunity to share information that will support the health needs of the patient moving forward. Please forward the information to the attention of:

Wesley Family Services
Attn: Medical Records
WFS OP Site Phone No.: _____
WFS OP Site Fax No.: _____

Do not hesitate to contact us should you have any questions regarding the outpatient treatment of this individual. We look forward to our ongoing collaboration.

Sincerely,

_____

wesley family services

ANNUAL WELLNESS EXAMINATION VERIFICATION

This form is to verify that _____ DOB _____
Is receiving outpatient treatment with Wesley Family Services. I/we have recommended the following treatments for a diagnosis of_____:

- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Pharmacotherapy
- ☐ Parent-Child Interaction Therapy (PCIT)
- ☐ Family/Couples Therapy
- ☐ Psychiatric Evaluation for Medication
- ☐ Diagnostic Assessment
- ☐ No Treatment Recommended

The last Annual Wellness Exam was on _____.

Results of blood work, concerns or additional information:
_____
_____
_____

_____
PHYSICIAN'S SIGNATURE

Completed form can be faxed to _____ or sent by mail to:

Wesley Family Services
_____

_____

FINANICAL RESPONSIBILITY AGREEMENT

Thank you for choosing Wesley Family Services (WFS) as your service provider. We are committed to helping you receive the best possible care available. Please understand that financial responsibility for services rendered are considered a part of your treatment. Kindly review the following so that you are aware of your financial responsibility for treatment at WFS.

INSURANCE COVERAGE

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations.
- We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.
- If you have had any changes in your insurance coverage you must notify us.

CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES

- I understand that I am responsible for the payment of any co-payments, co-insurance, or deductibles designated by my contract with my insurance provider.
- I understand that payments are due and payable prior to the service being delivered.
- If deemed medically necessary, from time to time we may allow you to continue in services and carry a balance via an agreed upon payment plan or send a statement for the balance due.
- Services that are not provided in a traditional office space setting will be invoiced once a month.

NON-COVERED SERVICES

- I understand that I am responsible for any fees not covered by my contract with my insurance provider and that these fees are due and payable at the time of service.

I understand that I will be asked to provide my consent for WFS to release to my insurance provider(s) for the sole purpose of establishing billing and payment services.

I acknowledge and accept my personal financial responsibility for services received at WFS.

I hereby assign any insurance and third party benefits for professional services rendered to me by Wesley Family Services and request that payment for any benefits assigned to these services be sent directly to:

Wesley Family Services
615 Alpha Drive
Pittsburgh, PA 15238

wesley family services

OUTPATIENT FEE SCHEDULE

Service Type	Fee
Initial Assessment (including Court Mandated D&A Assessment)	$110.00 (per event)
Ph.D. Assessment	$125.00 (per event)
Psychiatric Evaluation	$175.00 (per event)
Psychological Evaluation	$250.00 (per event)
Continued Stay Psychological Evaluation	$218.75 (per event)
Psychological Consultation (ISPT Meeting)	$26.25 (per 15 minutes)
Individual Therapy	$60.00 (16-37 minutes) $80.00 (38-52 minutes) $100.00 (53+ minutes)
Family Therapy	$100.00 (per hour)
Group Therapy	$45 (per hour)
Medication Checks	$100.00 (per event)

Wesley Family Services (WFS) Consent to Treatment
Family Services of Western Pennsylvania (FSWP)
Wesley Spectrum Services (WSS)

Client Name: _____ DOB: _____

Service(s) Offered):

☐ Acute Partial Hospital
☐ Behavioral Health Rehabilitation Services
☐ Intensive Family Coaching
☐ Case Management / Service Coordination
☐ Community Residential Rehabilitation Host Home
☐ Community & School Based BH
☐ Community Treatment Team
☐ Assertive Community Treatment Team
☐ ENGAGE
☐ Drug & Alcohol Outpatient
☐ Drug & Alcohol Intensive Outpatient
☐ Family Based/Family Focused
☐ Adult Diversion and Stabilization (DAS)
☐ Outpatient Mental Health
☐ Mental Health Intensive Outpatient
☐ Child and Adolescent Partial Hospital
☐ Parent Child Intervention Therapy
☐ Psychiatric Evaluation/ Medication Monitoring
☐ Mobile Medication
☐ Psychiatric Rehabilitation
☐ Mobile Psychiatric Rehabilitation
☐ School Based Behavioral Health
☐ Wonder Kids
☐ CARES Program
☐ IDD Residential Group Home
☐ IDD Vocational Services
☐ Other: _____

Statement(s) of Consent (initialed by the authorized consenting individual)

_____ Provide height and weight information (As required by the payer)

_____ Allow for intra-program collaboration among WFS providers

_____ I have authority to consent to these services as a parent or guardian, and I agree to inform WFS of any court orders and/or changes regarding such authority. (Copies of court documentation are required)

I have reviewed my (or my child's) treatment and services and understand the above information; and, I (We) voluntarily consent to services. I (We) have read, understand, and checked all the applicable statements above in which I (We) consent. We received information in an addendum* to this consent, which describes the services provided, and any risk and benefits associated.

Signatures

_____ _____
Parent/Guardian Date and Time Parent/Guardian Date and Time

_____ _____
Client Date and Time Other Date and Time

_____ _____
WFS Service Provider /Witness Date and Time WFS Service Provider /Witness Date and Time

(*Service description, benefits, risks and alternatives are described on the addendum attached)

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OUTPATIENT CONSENT ADDENDUM

Description of Services: Wesley Family Services (WFS) Outpatient Program (OP) provides outpatient services to individuals affected by mental health and substance use disorders as well as family members. Service offerings may include:

- INDIVIDUAL THERAPY
- GROUP THERAPY
- FAMILY THERAPY
- DIAGNOSTIC ASSESSMENTS
- PSYCHIATRIC ASSESSMENTS
- MEDICATION MANAGEMENT
- PARENT/PSYCHO-EDUCATIONAL GROUPS
- CONSULTATION AND COLLABORATION (AS APPLICABLE)
- DRUG AND ALCOHOL SERVICES
- MEDICATION ASSISTED TREATMENT
- AUTISM SERVICES

The Outpatient Program will assist individuals in their attempts to deal with behavioral disorders including substance use disorder, social issues, and related symptoms affecting their lives. The program will provide structure, support, and expectations but will be guided by an individual's immediate and long term needs. The program incorporates evidence-based interventions and treatment modalities in service provision, but is designed to be flexible so that services can be tailored to meet the needs of individual clients. The needs of any particular client group will be evaluated on a continuous basis, and it is anticipated that the program will change and evolve as more is learned about clients and their needs. If a client group has similar needs and goals, such as individuals affected by Autism or individuals suffering from substance use disorders, groups may be formed to better serve those clients and develop a support system.

All OP services provided will be based on our recovery philosophy: Recovery is an ongoing process that continues through life and is about restoration and personal growth; Recovery is about dignity and self-respect; Recovery means independence, personal responsibility and productivity; Recovery is about connecting in a fulfilling way with a community of other people; Recovery is about establishing meaningful relationships; Recovery allows the renewal of purpose, meaning and hope in life; Recovery is about overcoming stigma; and, Recovery from substance use and mental health issues through integrated services has successful outcomes when services begin at assessment.

If receiving medication management, the doctor will review the risks, benefits, and side effects of the medication with the client/guardian each time a medication is prescribed or changed.

Benefits: As the lowest level of care, Outpatient is designed to maintain clients and families in their home and community setting while focusing on specific, targeted goals in the OP office. The OP office can be in clinics, schools, and physician offices convenient to the family's home. Treatment is strengths-based and focuses on client-identified goals, placing the client in the driver seat of treatment. Clients can participate in individual or family sessions, or they can be identified for OP groups that are offered at various sites based on need. Treatment is available in specialty areas such as PCIT, trauma-focused, or autism with therapists who have acquired training specific to these areas. Outpatient is designed to be short-term and prevent higher levels of care or to be a step-down from more restrictive therapy settings.

Risks: Outpatient is not as intensive as most other levels of care. Clients hold some responsibility for scheduling and maintaining appointments which can be difficult for some clients. Outpatient therapy must be conducted within our offices to protect confidentiality. Clients may need to be referred to a higher level of care if their acuity rises throughout their time in therapy. Changing therapists can be frustrating for clients if they feel strongly connected to their OP therapist. There are also some risks associated with therapy as certain results or outcomes cannot be guaranteed.

Alternative Procedures/Treatments and their risks: Clients have the right to ask questions about anything that happens in therapy. We are always willing to discuss how and why we have decided to do what we are doing and to look at alternatives that might work better. Clients can feel free to ask us to try something that you think will be helpful. Clients can ask us about our training for working with your concerns and can request that we refer you to another therapist, to an alternative treatment/service, or to another agency if you decide we are not the right service and/or therapists for you. Outpatient clients have a choice in provider and can change providers at any time.

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WESLEY FAMILY SERVICES-WFS
Inclusive of member organizations,
FAMILY SERVICES OF WESTERN PENNSYLVANIA-FSWP
and
WESLEY SPECTRUM SERVICES-WSS
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Individual:	ID#:
Birthdate:	Social Security Number:
Type of release (check all that apply) Nature of Release ❑ VERBAL COMMUNICATION ❑ MAILED ❑ FAX ❑ EMAIL ❑ REQUEST FROM ❑ RELEASE TO	
WFS/FSWP/WSS Agency Program: Complete address including street, city, state, and zip code: Phone: Fax:	
Individual, Agency, WFS/FSWP/WSS Hybrid Program, etc.: Complete address including street, city, state, and zip code: Phone: Fax:	
The information below is to be released for the time period of **to**	
This authorization will expire on: **Event:**	

MENTAL HEALTH, PHYSICAL HEALTH, SUBSTANCE USE, AND HIV INFORMATION CONTAINED IN THE PARTS OF THE RECORDS INDICATED BELOW WILL BE RELEASED THROUGH THIS AUTHORIZATION UNLESS OTHERWISE INDICATED.
DO NOT RELEASE: ❑ MENTAL HEALTH ❑ SUBSTANCE USE ❑ HIV/AIDS ❑ PHYSICAL HEALTH

INFORMATION TO BE RELEASED
☐Active/Inactive Status ☐Assessment ☐Billing ☐Dates of Treatment ☐Diagnosis ☐Discharge/Transfer Summary ☐Emergency Contact
☐Individual Service/Treatment Plan ☐Labs ☐Medication Regimen ☐Nature of Treatment ☐Physician Progress Notes ☐Prognosis
☐Progress Notes ☐Psychiatric Evaluation ☐School Records
☐Other:_____

INFORMATION TO BE REQUESTED
☐Active/Inactive Status ☐Assessment ☐Billing ☐Dates of Treatment ☐Diagnosis ☐Discharge/Transfer Summary ☐Emergency Contact
☐Individual Service/Treatment Plan ☐Labs ☐Medication Regimen ☐Nature of Treatment ☐Physician Progress Notes ☐Prognosis
☐Progress Notes ☐Psychiatric Evaluation ☐School Records
☐Other:_____

FOR THE PURPOSE OF: ❑ CONTINUITY AND COORDINATION OF CARE ❑ OTHER:

Consent to Release Information: I have read this Authorization or had it explained to me and I understand its contents.

Individual/Representative Signature:	Printed Name:	Date:
Representative Relationship: ☐Power of Attorney (attach copy) ☐Guardianship Order (attach copy) ☐Parent of Minor ☐Other:_____		
Staff Signature:	Printed Staff Name:	Date:

COPY ACCEPTED BY INDIVIDUAL/REPRESENTATIVE: ❑ YES ❑ NO **❑ REFUSED**

I understand that this Authorization is effective for a period of one year from the date of the signature, unless otherwise specified. The time frame may not exceed one year from the date of signature. I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that FSWP, WSS, and WFS have already acted upon it, or if this Authorization was signed as a condition of obtaining insurance coverage. In order to revoke this Authorization, I understand that I must revoke it in writing to FSWP, WSS, and WFS have forms for you to use to revoke this Authorization at any time before it expires. I may refuse to sign this authorization and I understand that my refusal will not impact my ability to receive treatment from this agency.
I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me under the Health Insurance Portability and Accountability Act (HIPAA) regulations. For information related to substance abuse and/or HIV, state law prohibits making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.
FOR AUTHORIZATION FOR RELEASE OF SUBSTANCE ABUSE/TREATMENT, HIV RELATED, AND/OR MENTAL HEALTH INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania state and federal laws, including 42 C.F.R., each of which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.

ORAL AUTHORIZATION (ONLY FOR PERSONS PHYSICALLY UNABLE TO SIGN)
THIS IS NOT APPLICABLE TO HIV RELATED OR DRUG/ALCOHOL TREATMENT INFORMATION.
My verbal consent to the above authorization and my verbal statement of understanding of this authorization has been witnessed by the two individuals whose signatures appear below.

Witness Signature:	Printed Name:	Date:
Witness Signature:	Printed Name:	Date:
Reason unable to provide signature:		

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CONSENT TO DRUG TESTING

I understand that the outpatient programs at Wesley Family Services utilizes "random" and "for-cause" drug testing as a way of monitoring individual's recovery process. I understand that as an individual receiving services in that program, I may be subject to a test at the discretion of interdisciplinary treatment team. I understand that I have the right to refuse to be tested. If I refuse, my treatment team will work with me to determine the next steps.

My signature below reflects that I am willing to submit to a urinalysis test if asked by a member of my interdisciplinary treatment team. I understand that my signature acknowledges drug testing as part of my treatment regimen and that I consent to be tested. I also understand that I must provide written consent, signed by me, to release any part of my drug and alcohol record, including drug testing results, to outside parties. I understand that such consents, as with this consent, can be revoked by me at any time either verbally or in writing.

Signatures

_____		_____	
Parent/Guardian	Date	Parent/Guardian	Date
_____		_____	
Client (14 years of age or older)	Date	Other	Date
_____		_____	
WFS Staff Explaining Procedure	Date	WFS Service Provider /Witness	Date

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OUTPATIENT POLICY & PROCEDURE ACKNOWLEDGEMENT FORM

Client Name: _____ DOB: _____

By Initialing below, I acknowledge that:

_____ I have received and understand the WFS **Complaint/Grievance Policy and Procedure**.

_____ I have received and understand the WFS **Client Rights and Responsibilities**.

_____ I have received and understand WFS **Client Financial Responsibility Agreement and Fee Schedule**.

_____ I agree to inform Wesley Family Services of any changes in my/my child's demographic and/or insurance information to ensure uninterrupted care.

_____ I have received and understand WFS

- **Attendance Procedure**
- **Outpatient Crisis Supports**
- **Outpatient Consent Addendum**

_____ I understand that if I am receiving more than one WFS service, the staff from the programs will collaborate with each other regarding my care, which would include sharing assessment, service planning, and/or treatment planning information. If I do not want this collaboration to occur, then I can inform my assigned staff.

Signatures

_____ _____
Client (14 years of age or older) Date

_____ _____
Parent/Guardian Date

_____ _____
Other Date

_____ _____
Witness Date

wesley family services

VOTER REGISTRATION DECLINATION FORM

Name (Please print: Last Name, First, M.I)

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE TODAY?

☐ Yes Registration form provided _____ Registration form mailed _____

☐ No OR ☐ No, I am already registered to vote where I live now.

IF YOU DECIDE NOT TO CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you apply to register to vote, the office at which you submit this registration application form will remain confidential.

No information relating to a preference to register to vote will be used for any purpose other than for voter registration.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

In order to be qualified to register to vote, you must be at least 18 years of age on the day of the next election, you must have been a citizen of the United States for at least one month prior to the next election and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election, and you must not have been confined to a penal institution for a conviction of a felony within the last five years.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office Building, Harrisburg, PA 17120, or call the Department of State, toll-free, at 1-800-552-8683

For staff only: If client refuses to check or sign the above, print their name and provide the date above and then place your initials here. _____

_____ _____

Signature Date