Idaho State University

ISU Community Psychiatric Center
421 Memorial Dr., Bldg. 82 | Pocatello, ID 83201
Phone: 208.282.2434 / Fax: 833.390.1293

Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text Carrier:		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender	
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:	Preferred Pronoun:	
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:			
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline			Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one):	☐ English ☐ Sign Language	☐ Bosnian ☐ Spanish	☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Other
Preferred Pharmacy Name & Location:			

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name & Provider Phone No.:	Ins. Co. Name & Provider Phone No.:
Policy Holder Name:	Policy Holder Name:
Policy Holder Address if different than patient:	Policy Holder Address if different than patient:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy No.:	Policy No.:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____

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Client Intake Information

Please answer all information as completely as possible. Information given is strictly confidential within the limits of the law and beneficial in providing the best possible service. Feel free to ask for assistance. Your counselor will discuss your responsibilities with you in your initial session.

ISU Community Psychiatric Center does not get involved with any legal or disability-related issues or claims.

CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Preferred Pronoun (eg: she, he, ze, they): _____ Self-identified Gender: _____

Biologic Sex: _____ Sexual Orientation: _____

Primary Language: _____

Parent/Guardian Name (If client is a minor): _____
Client Address: _____
_____

Cell phone: _____
May call: ☐ Yes ☐ No
May leave message: ☐ Yes ☐ No

Home phone: _____
May call: ☐ Yes ☐ No
May leave message: ☐ Yes ☐ No

Email: _____
May email: ☐ Yes ☐ No

Current Occupation: _____ Level of Education Completed: _____

Relationship status (ex: Single, married, divorced, separated, significant relationship/s, etc.): _____

Received prior counseling or mental health treatment? ☐ Yes ☐ No
If yes, please explain: _____

In case of emergency, please contact:
Name: _____ Relationship: _____ Phone: _____

Have you received prior counseling or mental health treatment? ☐ Yes ☐ No
If yes, please explain:
_____
Was it helpful? ☐ Yes ☐ No Please explain: _____

What psychiatric medications have you tried in the past?

Medication Name	Strength	Directions	Prescriber	Outcome

PRESENTING PROBLEMS AND CONCERNS

Please describe your reason for seeking treatment at this time and how you will know if it is working:

Have you ever or are you currently contemplating ending your life? □ No □ Yes If yes, when?_____

Has anyone in your immediate family attempted or completed suicide? □ No □ Yes If yes, when?_____

Please circle any of the following that are currently troubling you: For all of those which you circle, please indicate on a scale from 1 to 10, with 10 being significant, how severe you feel this issue is in your life at the present time.

Abuse	Family	Motivation	Stress
Alcohol/Drug use	Fear	Perfection	Study habits
Anger/Rage	Finances	Procrastination	Suicidal thoughts
Anxiety/Panic	Friends	Relationship	Test anxiety
Appearance/Weight	Grades	Sadness	Time management
Assertiveness	Grief	Self-esteem	Trust
Boredom	Guilt	Sexual harassment	Unhappiness
Career	Helplessness	Sexuality	Worry
Dating	Homesickness	Shyness	Other:
Depression	Hopelessness	Sleep	Other:
Eating problems	Loneliness	Stalking	Other:
Expressing feelings	Meeting people	Staying in school	

Present Family/ Living Situation

Please identify the people currently living with you and the nature of your relationship.

	Name	Age	Relationship	Currently this relationship is: Good, neutral, conflicted, etc.
1				
2				
3				
4				
5				
6				

HISTORY

Health

Are you currently under the care of a medical doctor or other medical health professional: □ No □ Yes
Name of Primary Care Physician:_____
Physician Phone : _____

Are you currently taking any prescription medications, vitamins or herbal supplements ? □ No □ Yes
If yes, please list each medication below (please include Over-The-Counter Medicines, Dietary Supplements, and Herbal remedies):

Medication Name	Strength	Directions	Prescriber

Do you have any allergies? □ No □ Yes If yes, please list: _____

Date of last physical exam: _____ Any significant results: _____

Physical disability: □ No □ Yes Chronic illness: □ No □ Yes

If yes to either, please explain: _____

Prior psychiatric hospitalizations? □ No □ Yes If yes, when: _____

Do you currently exercise: □ No □ Yes If yes, please indicate what type and how many times per week:_____

Are you having any problems with your sleep habits? □ No □ Yes If yes, please explain:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes If yes, please explain:

Have you or are you currently using any of the following substances?

Substance	Past or Present use?	Frequency/Amount	Method of use	Level of concern
Caffeine □ No □ Yes				
Alcohol □ No □ Yes				
Tobacco □ No □ Yes				
Recreation or Street Drugs □ No □ Yes (Please list)				
Marijuana/CBD/ Cannabis □ No □ Yes				
E-cigarettes/vape pen □ No □ Yes				

What medical problems have you been diagnosed with (for example, high blood pressure, diabetes, etc):

Diagnosis	Provider who treats	Date diagnosed	How well controlled?

What surgeries have you had (for example, C-section, open heart surgery, back surgery):

Diagnosis	Provider who treats	Date diagnosed	How well controlled?

Have you ever had a head injury, seizure, motor vehicle crash, or motorcycle accidents? If so, please describe:

Type of injury	Date	Treatment given?	Loss of consciousness?

Have you ever been the victim of a crime? □ No □ Yes
If yes, please list date and briefly describe: _____

Are you currently involved in divorce or child custody proceedings? □ No □ Yes
If yes, please explain: _____

Have you ever been convicted of a misdemeanor or felony? □ No □
If yes, please explain:

Cultural Beliefs Affecting Treatment

What culture do you identify with?

Strengths and Interests

What are your strengths and interests?

GOALS

What are the goals you hope to achieve in treatment:

1.

2.

3.

Is there anything you would like to add that I have not asked which you would like to include?

Client Signature: _____ Date: _____
Parent/Guardian Signature if under 18: _____ Date: _____
Parent/Guardian Signature if under 18: _____ Date: _____

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Agreement for Comprehensive Mental Health Services

I, _____, the client, agree to meet with a licensed provider of the ISU Community Psychiatric Center at the appointment times and places we agree on, starting on _____, 20____.

With enough knowledge, and without being forced, I enter into treatment with ISU Community Psychiatric Center, I will keep my provider fully up-to-date about any changes in my medications, medical diagnoses, feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interests.

Confidentiality: I understand that the ISU Community Psychiatric Center abides by the ethical codes established by the Health Insurance Portability & Accountability Act (HIPAA) and the rules and statutes governing the practice of counseling and use of prescription medication in the State of Idaho. These ethical codes and legal statutes require providers to report to responsible persons or state agencies when clients indicate any of the following situations:

- **That the client intends to harm self**
- **That the client intends to harm someone else**
- **Information as to direct involvement in child abuse or neglect**
- **Information as to direct involvement in abuse of the elderly or disabled**

I also understand confidentiality is limited by the use of supervisory sessions involving practicum students, interns, residents, and supervisors.

Duration of Treatment: Progress will be evaluated at each session every 90 days and parts of this agreement may change as needed. Follow up will be based on discussions with my provider. Our goals may change over the course of treatment in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make changes in this agreement, and I may stop treatment after giving this provider at least 7 days' notice of my intentions and meeting with the provider for one last time. I understand that I must make and keep follow up appointments at the recommended intervals in order to receive prescription refills. Should I decide to terminate services, I understand I may receive a 30-day supply of refills at my last session.

Request for Paperwork or Documentation: Requests for paperwork or documentation requiring provider assessment including FMLA, an ESA letter, school or work accommodations, etc. will not be completed at the first visit. Paperwork will be completed at the discretion of the provider once there is a therapeutic relationship and the patient is actively engaged in treatment. Patients requesting paperwork must schedule an appointment with the provider to discuss. The clinic does not routinely complete disability paperwork and instead referral will be placed for unbiased evaluation. This will be considered on a case by case basis.

Medical Records: Medical records are not part of academic records, and no one, other than ISU Community Psychiatric Center staff, have access to them except under the limits of confidentiality. Complete records are maintained for seven years from the date of our last contact with you. Upon your written request, we will provide appropriate written information regarding your counseling to another licensed mental health care provider or physician of your choice. If you request a release of information to any other individual, we will request personal contact with you in addition to the written release. Your medical record with us is maintained

in both paper file and electronic file formats. Both formats are considered confidential, and access to them is restricted to the conditions previously stated.

Fee for Service: This agreement shows my commitment to pay for this provider's services. It also shows this provider's willingness to use and share his or her knowledge and skills in good faith. I agree to pay in cash, check, or debit/visa any deductible, co-payments, or co-insurance at the time of service.

No Show/Cancellation Policy: We understand that life can sometimes get in the way of scheduled appointments. However, missed appointments not only inconvenience our center but also prevent other patients from receiving the care they need. To ensure the best possible service for all our patients, we have implemented the following no-show and cancellation policy:

- **No-Shows:** A no-show" is defined as missing an appointment without canceling or rescheduling at least 24 hours in advance. If a patient fails to show up for a scheduled appointment without prior notice, they will be marked as a no-show. Patients will be discharged and unable to receive services after 3 no-shows.
- **Cancellations:** Patients are encouraged to provide at least 24 hours' notice if they need to cancel or reschedule an appointment. This allows us to offer the appointment slot to another patient in need of care.
- **Late Arrivals:** Patients arriving 10 minutes after the scheduled appointment time may be seen on the discretion of the provider. Arrivals after 15 minutes will have to be rescheduled.
- **Communication:** It is the responsibility of the patient to ensure that the clinic has their current contact information on file. We will make every effort to remind patients of upcoming appointments via phone, email, or text message, but ultimately, it is the patient's responsibility to keep track of their appointments.

My signature below indicates that I understand and agree with all of the above points.

_____

Patient Name

_____ _____

Signature of Patient Date

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Consent for Treatment / Statement of Financial Responsibility

Consent for Treatment

I consent to the use or disclosure of my protected health information by the ISU Community Psychiatric Center staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or disclosed for the above purposes.

ISU Community Psychiatric Center is not required to agree to such a request, but if agreed upon, the center will comply unless the information is needed to provide me emergency treatment.

The "Notice of Privacy Practices describes my rights as well as ISU's rights and responsibilities with respect to my protected health information.

Billing Policy

We are happy to bill your private insurance as long as you provide us with a copy of your insurance card front and back. In cases where we cannot direct bill your insurance, we will provide you with a copy of your charges to send in to your insurance company. By signing this form, you agree to the following authorizations and policies.

- I authorize release of any protected health information to my insurance company necessary to process an insurance claim.
- I authorize ISU Community Psychiatric Center to act as my agent in helping me to obtain payment from my insurance company.
- I authorize payment to be made directly to my doctor/clinic.
- I understand that I am responsible for any legal or collection fees if my account is turned over to collections for non-payment.

ISU Community Psychiatric Center and its staff cannot guarantee insurance payments or benefits for any insurance company.

If your insurance company denies the claim or pays only a portion of it, you are responsible for the balance. A monthly statement will be sent to you. Be sure we have your correct address and phone number on file. We are happy to assist you with a payment plan if needed. Just let us know how we can help.

If your insurance company denies the claim or pays only a portion of it, you are responsible for the balance.

Photography/Other Images

I understand that my photographs, videotapes, digital or other images may be used to assist with diagnosis and treatment.

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Email/Text Reminders

I authorize ISU Community Psychiatric Center to send appointment reminders via:

☐ Text ☐ Email: _____

☐ No reminders via text or email.

I have read and understand the content of this form.

_____ _____
Print Name of Patient or Personal Representative *Date*

_____
Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Controlled Substances Agreement

I, _____, a patient of **ISU Community Psychiatry Center** have been informed that individuals who are prescribed certain controlled substances including, but not limited to stimulants, benzodiazepines, barbiturate sedatives, and narcotics can abuse those substances or may allow abuse by others. They have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this agreement as consideration for, and as a condition of, the willingness of the physician to continue to prescribe controlled substances.

1. All controlled substances must come from a physician in **ISU Community Psychiatry Center's** office. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific written authorization is obtained from the office for an exception.
2. I understand I will be required to be seen **at least** every 3 months by in person visit if I am provided a controlled substance.
3. I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication. Failure to comply may result in immediate discharge from the practice. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.
4. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by my physician.
5. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal, and over dosage.
6. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report or a statement from me explaining the circumstances may be required before additional prescriptions are considered. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, physician can consider discharge from clinic.
7. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.
8. I understand refills generally will not be given over the phone, after office hours, during the weekends, and on holidays.
9. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
10. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
11. I will inform my other health care providers that I am taking the controlled substances listed above, and of the existence of this agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

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12. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.

13. I will not allow anyone else to have, use sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is against the law.

14. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

15. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.

16. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by physician.

17. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.

18. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.

19. I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name of Physician

_____ _____
Signature of Physician *Date*

Idaho State University

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Telehealth Patient Consent Form

Purpose: The purpose of this form is to get consent for participation in a model of healthcare called telehealth. Telehealth involves the use of electronic communications to enable healthcare providers to share individual patient medical information for the purpose of improving patient care and providing care at a location separate from the provider. ISU will be using ZOOM remote technology to evaluate/re-evaluate virtually, to help manage your hearing needs. Also, our providers will determine whether you have a condition that requires in-office treatment.

What is a Telehealth Consultation: Telehealth is a tool used to help people who cannot go to a healthcare provider's office to receive an examination or consultation. Telehealth uses electronic records including your health history and other information. Your consultation with the provider and these records will be used to address your health concerns or recommend further treatment.

What are the Risks, Benefits, and Alternatives?: The benefits of telehealth include having access to a healthcare provider without travelling to a provider's office or clinic. A potential risk of telehealth is that a face-to-face consultation with a healthcare provider may still be necessary after the telehealth appointment. At any time during the consultation, you may choose to end the session and seek care in our clinic based on availability.

Confidentiality: Current federal and Idaho laws about confidentiality apply to the information used or disclosed during your telehealth consultation. In rare cases, some of your records may unintentionally become available to people not connected with the consultation. You will be provided with a separate document, which describes how your private information will be handled. This is known as the "Notice of Privacy Practices."

Rights: You may choose not to participate in a telehealth consultation at any time before and/or during the consultation. If you decide not to participate it will not affect your right to future care or treatment. You have the option to seek consultation or treatment in an office at any time before or after the telehealth consultation.

Fees associated with Telehealth: If you have insurance that covers your services via telehealth, we will submit your telehealth visit to your insurance for processing. If your services are considered non-covered, there may be a fee associated with the visit that will be your responsibility.

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth and billing that may be related to my telehealth consultation.

_____ _____

Patient/Guardian Signature Date

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Authorization to Obtain Emergency Medical Treatment

I authorize the ISU Community Psychiatric Center to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Community Psychiatric Center Notice of Privacy Practices.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date

Notice of Privacy Practices

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

Our Legal Responsibility

At Idaho State University, we are committed to protecting our patients' personal and health information. Under the Health Insurance Portability and Accountability Act (HIPAA) federal law gives individuals a fundamental right to be informed of the privacy practices of their health care providers, as well as to be informed of their privacy rights, with respect to their personal health information. We are legally required to protect the privacy of your health information, and to give you this Notice about or legal duties, privacy practices, and your rights with respect to your health information.

In this Notice, personal and health information is referred to as "health information" and includes your name, age, address, income or other financial information. We follow the privacy practices described in this Notice, while it is in effect. This Notice takes effect December 1st and will remain in effect until replaced.

If you have any questions about this Notice, if you want to exercise any of your rights listed in this Notice, or if you feel that your privacy rights have been violated, please contact ISU's HIPAA Compliance Officer, Misty Olmsted at (208) 282-4380 or by email at hipaa@health.isu.edu.

Protecting your Health Information

We protect your health information by:

- Maintaining the privacy and security of your health information as required by law.
- Letting you know if a breach occurs that may have compromised the privacy or security of your information.
- Following the privacy practices described in this notice and giving you a copy.

Uses and Disclosures of Your Health Information

We are allowed, by law, to use and disclose your health information with others without your authorization for many reasons. These examples describe different ways we may use or disclose your information. Please note that not each use or disclosure in each category is listed and these are general descriptions only.

- **Treatment**: We may provide another physician or subsequent healthcare provider who is treating you, with copies of various reports of your health information, that should assist them with your treatment.
    - Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
    - Example: We give information about you to your health insurance plan so it will pay for your services.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, training medical students, conducting training and educational programs, accreditation, certification, licensing or credentialing activities.
    - Example**:** We use health information about you to manage your treatment and services.
- **Appointment Reminders:** We may use health information about you to call, leave a voice message, text, email, or send a postcard or letter to you as a reminder about an appointment.
- **Public Health Disclosures:** We may disclose medical information about you for public health reporting purposes, such as preventing or controlling disease; reporting adverse events related to medications or medical products.
- **Law Enforcement:** We may release medical information, as authorized or required by law to identify suspects, fugitives, missing persons or material witnesses, to law enforcement.

- **Criminal Activity:** We may disclose your health information, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Abuse or Neglect:** We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court or administrative orders, subpoenas, discovery requests, other lawful process, or to defend ourselves against a lawsuit brought against us
- **Research:** Under certain limited circumstances, we may use and disclose health information about you for research purposes. All research projects are subject to a special approval process.
- **Organ, eye and tissue donation:** If you are an organ, eye or tissue donor, we may release medical information to organizations that handle organ, eye, or tissue procurement or transplantation; or to an eye, organ or tissue donation bank, as necessary to help with procurement, transplantation or donation.
- **Workers' compensation:** We may disclose medical information about you for Workers' compensation or similar programs as authorized or required by law.
- **Coroners, medical examiners and funeral directors:** We may disclose medical information to a coroner or medical examiner, and to funeral directors, as needed for them to carry out their duties.
- **Government Officials**: As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the U.S. President, other authorized persons or foreign heads of state.
- **Business Associate:** We may share your medical information with third-parties referred to as "business associates" that provide various services on the behalf of ISU clinics, such as billing, transcription, software maintenance and legal services.
- **Parental Access:** Some state laws concerning minors permit or require disclosure of protected health information to patients, guardians or persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.
- **Fundraising:** We may use or disclose your information in order to contact you for fundraising activities. You have the right to opt out of these fundraising communications.

Uses and Disclosures Made with Your Authorization

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

- **To Your Family and Friends:** We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care:** We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member of your personal condition, or death. If you are present,

prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

- **Marketing Health-Related Services:** We will not use your health information for marketing without a written authorization from you.
- **Psychotherapy Notes:** Psychotherapy notes, made by your individual mental health provider during a counseling session, expect for certain limited purposes, related to treatment, payment and healthcare operations, or other limited exceptions, including government oversight and safety, will be disclosed with your authorization.
- **Sale of Medical Information:** We will not sell your health information to third parties without your authorization. Except certain purposes that are permitted under the regulations.
- If you give your authorization, you may change or revoke it at any time by giving us written notice. Your revocation will not be effective for uses and disclosures already made.

Your Rights Regarding your Health Information

You have the right to request all of the following:

- **Access to Your Health Information:** You have the right to request and receive a copy of your health information, including all billing information, in paper or electronic form. A reasonable fee may be charged for providing copies. However, this right does not include the following types of records: psychotherapy notes; records compiled in reasonable anticipation of a court action or administrative action or proceeding; and protected health information whose release is prohibited by federal or state laws. Access to your records may also be limited if it is determined that by providing the information it could possibly be harmful to you or another person. If access is limited for this reason, you have a right to request a review of that decision. If we maintain the medical information electronically and you request an electronic copy, we will give the information to you in the format you request, if it is readily available. If we cannot readily get the record in the form and format you request, we will give it in another readable electronic or paper format that we both agree to.
- **Amendment:** You have the right to request, in writing, an amendment to your health information. The request must identify which information is incorrect and an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make reasonable effort to include the amended information in future disclosures. (Amending a record does not mean that health information will be deleted.)
- **Accounting or Disclosures:** If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
- **Restriction Requests:** You have the right to request that the clinic place additional restrictions on uses and disclosures of your health information. For example, when you have paid for your services out of pocket in full,

at your request, we will not share information about those services with your payer, as long as such disclosure is not required by law. For all other requests, we may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

- **Confidential Communication:** You have the right to request that communication regarding your health information be done in an alternate way or be sent to an alternate location.
- **Electronic Notice:** If you received this notice by accessing a web site or by email, you are also entitled to have a paper copy which is available by request from the clinic or department.
- **Notification in the Case of a Breach:** We are required by law to notify you of a breach of your unsecured medical information. We will give such notification to you without unreasonable delay but no later than 60 days after we discover the breach.

Changes to this Notice

We reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may also request a copy of the Notice at any time.

Questions and Complaints

To file a complaint if you feel your privacy rights have been violated, or if you would like to request a Restriction, request an Accounting of Disclosures or revoke an Authorization, please contact:

Misty Olmsted, HIPAA Compliance Officer
Office of General Counsel
921 S. 8th Ave, Stop 8410
Pocatello, ID 83209
(208) 282- 4380
hipaa@health.isu.edu

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
US Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.,
Washington, D.C. 20201,
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/
If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

Notice of Privacy Practices

Contacts

To Request your medical or billing information please contact the ISU Clinic directly.

ISU Student Health Center- Pocatello 990 Cesar Chavez Ave., Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8311 Pocatello, ID 83209	ISU Bengal Pharmacy-Pocatello 990 Cesar Chavez Ave., Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8158 Pocatello, ID 83209	Pocatello Family Dentistry 465 Memorial Drive Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8088 Pocatello, ID 83209
ISU Speech and Hearing Clinic-Pocatello 650 Memorial Dr., Bldg. 68 Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8116 Pocatello, ID 83209	ISU Dental Hygiene 999 Martin Luther King Jr. Way Pocatello, ID 83209 Billing Address: 921 S 8th Ave, Stop 8048 Pocatello, ID 83209	ISU PT/OT Clinic-Pocatello 1400 E Terry Dr., Bldg. 63 Pocatello, ID 83209 Billing Address: 921 S. 8th Ave., Stop 8045 Pocatello, ID 83642
ISU Integrated Mental Health 1311 E Central Drive Meridian, ID 83642 Billing Address: Same as Above	ISU Family Dentistry 1311 E Central Drive Meridian, ID 83642 Billing Address Same as Above	ISU Meridian Healthcare 1311 E Central Drive Meridian, ID 83642 Billing Address: Same as Above
ISU Speech & Language Clinic Meridian 1311 E Central Drive Meridian, ID 83642 Billing Address: Same as Above	ISU PT/OT Clinic-Meridian 1311 E Central Drive Meridian, ID 83642 Billing Address: 1311 E. Central Dr. Meridian, ID 83642	ISU Speech & Hearing Clinic-Salmon 805 Main St. Salmon, ID 83467 Billing Address: 921 S 8th Ave., Stop 8116 Pocatello, ID 83209
ISU Community Psychiatric Center 421 Memorial Dr., Bldg. 82 Pocatello, ID 83201 Billing Address: 921 S. 8th Ave., Stop 8311 Pocatello, ID 83209		