Thank you for contacting Common Threads Family Resource Center. We hope that our center will be able to meet your clinical needs.

In order to set up the first appointment, please complete and return the attached Intake Packet, a prescription for the services you are requesting, and a copy of your current insurance card (front and back). You will be contacted for appointment times once these items have been received and processed.

Return to:

Michael Jones
Common Threads Family Resource Center
5979 Siggelkow Road
McFarland, Wisconsin 53558

If you have any further questions please contact Michael at 608-838-8999.

We look forward to meeting with you!

Common Threads Family Resource Center
5979 Siggelkow Rd McFarland, WI 53558
Phone: 608.838.8999 ~ Fax: 608.838.8988

CLIENT INFORMATION SHEET

Client Name: ______________________ Age: ______ Date of Birth: ______________ Sex: Male Female

Social Security #: ______________________ Address: ______________________ Phone #: ______________

Guardian #1: ______________________ Guardian #2: ______________________

Address: ______________________ Address: ______________________

City/State: ______________ Zip Code: __________ City/State: ______________ Zip Code: __________

Cell #: ______________ Work #: ______________ Cell #: ______________ Work #: ______________

E-mail: ______________________ E-mail: ______________________

SS # (If primary insurance carrier): ______________ SS # (If primary insurance carrier): ______________

Emergency Contact: ______________________ Phone #: ______________ Relationship to Client: __________

INSURANCE INFORMATION:

Referring Physician: ______________________ Physician's Phone #: ______________

Physician's NPI #: ______________________

Primary Insurance: ______________ Policy #: ______________ Group #: ______________

Contact Phone Number: ______________ Address: ______________________

Secondary Insurance: ______________ Policy #: ______________ Group #: ______________

Contact Phone Number: ______________ Address: ______________________

Please include copies of all insurance cards

☐ I do not have insurance benefits to cover the services I will be receiving and agree to pay my bill personally at the time of services. If I am unable to pay in full, I will make payment arrangements with Common Threads Family Resource Center, LTD. (Please check box if this statement applies.)

Signature on File: (If you would like us to file claims with your insurance carrier, the INSURED's signature is required below.)

- I authorize use of this signature form on all my insurance submissions.
- I authorize Common Threads Family Resource Center and their billing agency to release to my insurance company any medical information necessary to process my claims.
- I understand that I am responsible for payment of all fees, co-pays, co-insurance, and deductibles. I understand that Common Threads and their billing agency will prepare insurance forms or reports to assist me in obtaining benefits from my insurance company.
- I authorize Common Threads Family Resource Center and their billing service to act as my agent in helping to obtain payment from my Insurance Company (s).
- I authorize payment direct to Common Threads Family Resource Center, LTD.
- I permit a copy of this authorization to be used in place of the original.
- I understand that this consent may be revoked by me at any time, except to the extent that action has already been taken. This consent remains valid unless expressly revoked.
- I hereby release Common Threads Family Resource Center and their billing agency from any legal responsibility or liability that may arise from the act of filing my insurance claim.

Name: (please print) ______________________ Date: ______________________

Signature: ______________________________

CLIENT INFORMATION

Client's Name: ______________________ **Client's Date of Birth:** ____________

Client's Diagnoses:

Diagnosis: ____________ Date Given: ____________ By Whom: ____________
Diagnosis: ____________ Date Given: ____________ By Whom: ____________
Diagnosis: ____________ Date Given: ____________ By Whom: ____________
Diagnosis: ____________ Date Given: ____________ By Whom: ____________

Medications:

Current Medications: ____________ Dosage: ____________
Current Medications: ____________ Dosage: ____________
Current Medications: ____________ Dosage: ____________
Current Medications: ____________ Dosage: ____________

What is the main issue for which you are seeking help?

Additional Signs and Symptoms:

Impact on daily life:

History of Presenting Problem:

Events or incidents causing client(s) to seek services:

Frequency/duration/severity of symptoms:

Client's Name: ______________________________

Was there a time when symptoms worsened or lessened:

____
____
____
____

What would be your priorities/goals that you would like to accomplish as a result of therapy services?

____
____
____
____
____
____

Is there anything that would be helpful to know about you/your child prior to evaluation?

____
____
____
____
____
____

Who were you referred by?
Name: ______________________________ Agency/Clinic: ______________________

Please list the contact information for any of the following services that you have received including names, contact information, dates of services and duration of services. No contact will be initiated without your consent.

Occupational Therapy: ________________________ Date(s) Seen: __________________
Outcome:____
____

Physical Therapy: ________________________ Date(s) Seen: __________________
Outcome:____
____

Speech Therapy: ________________________ Date(s) Seen: __________________
Outcome:____
____

Psychologist/Mental Health Therapy: ___________________ Date(s) Seen: __________________
Outcome:____
____

Vision Therapy: ________________________ Date(s) Seen: __________________
Outcome:____
____

Client's Name: ______________________________

Neurologist/Psychiatrist: ________________________ Date(s) Seen: __________________
Outcome:____
____

Other: ________________________ Date(s) Seen: __________________
Outcome:____
____

Allergies: ____

Any serious medical conditions:
____
____
____

Physical factors affecting condition:
____
____
____

FUNCTIONAL SKILLS

Please describe toileting skills. Include occurrence of daytime and nighttime accidents and awareness of toileting need.
____
____

Please describe your child's eating habits. If your child is a picky eater please include the foods that they will eat.
____
____

Describe how your child transitions between people and environments. Please include what strategies that you have found helpful.
____
____
____

Please describe your child's typical routines.
Wake-up routine:
____
____

Client's Name: ______________________________

Bed-time routine:

____

____

During the night:

____

____

Does your child seem irritable during predictable times of day? If yes please describe what seems to trigger irritability.

____

____

____

For the following tasks, please describe your child's level of independence with ratings as follows:

1- fully dependent, you need to do this task for your child
2- your child is participating in the task, however, you are fully guiding the task
3- your child is completing some of the task independently
4- your child needs some reminders and cues in order to be successful with the task
5- your child is able to complete this task without any assistance for an adult

Dressing	
Putting on a pull over shirt	1 2 3 4 5
Putting on pants	1 2 3 4 5
Putting on undergarments	1 2 3 4 5
Putting on socks	1 2 3 4 5
Putting on slip on shoes	1 2 3 4 5
Getting undressed	1 2 3 4 5
Putting on a coat	1 2 3 4 5
Zipping a coat	1 2 3 4 5
Buttoning a shirt	1 2 3 4 5
Snapping pants	1 2 3 4 5
Tying shoes	1 2 3 4 5
Orienting clothing correctly	1 2 3 4 5

Grooming	
Washing hair	1 2 3 4 5
Brushing Teeth	1 2 3 4 5
Washing body	1 2 3 4 5
Washing hands	1 2 3 4 5
Combing hair	1 2 3 4 5

Eating	
Uses an open cup	1 2 3 4 5
Drinks from a straw	1 2 3 4 5
Uses a fork	1 2 3 4 5
Uses a spoon	1 2 3 4 5
Uses a knife to cut soft food	1 2 3 4 5
Serves self at table	1 2 3 4 5
Uses napkin to wipe face/hands	1 2 3 4 5

Safety	
Cross the street safely	1 2 3 4 5
Use safety precautions in a parking lot	1 2 3 4 5
Remain in safe proximity to the adult in public places	1 2 3 4 5
Navigate the playground safely (ledges, moving swings, etc)	1 2 3 4 5
Does your child respond to pain as you would expect?	Yes No Sometimes
Does your child fall or get hurt often?	Yes No Sometimes

CHILD INFORMATION SHEET

Child's Name: ______________________

Childhood/Developmental History:

Developmental milestones, past concerns, abuse, school, social, mental health, medical, etc.

____
____
____
____
____
____
____
____
____
____
____
____
____

Please describe your child's living situation. Including who lives in the home with your child:

____
____
____
____
____

Does your child have any siblings? Please include names and ages:

____
____
____
____

Does your child currently or have they ever had an Individualized Education Plan (IEP)? YES NO
If yes, is there anything that you feel would be important for us to know regarding your child's IEP?

____
____
____

Common Threads Late Cancellation and No Call/No Show Policy

Client's Name: ______________________________ DOB: ______________________

Parent/Guardian's Name: ________________________ Date: ______________________

Late-cancelled appointments and No Call/No Show appointments compromise the ability of Common Threads Family Resource Center to provide appropriate and consistent care to the needs of our clients.

If you must reschedule or cancel an appointment, please do so 24 hours prior to the scheduled time of your session or it will be considered a "Late Cancel". If you arrive 15 or more minutes late to the scheduled appointment time, you may be asked to reschedule, and the appointment will also be considered a "Late Cancel". All clients are charged a $50.00 fee for "Late Cancel" appointments.

Clients who do not contact the clinic to cancel scheduled appointments and do not show for scheduled appointments will be considered No Call/No Show and will be charged a $80.00 fee for "No Call/No Show" appointments.

We strictly adhere to this cancellation policy, but you are encouraged to speak with your individual therapist should special/emergency circumstances arise.

Insurance Companies, CCS Dane county, Community Partnerships, County Programs and/or Family Support and Resource Center will not pay for any missed appointments. They also will not cover the fees related to a Late Cancel or a No Call/No Show appointment.

It is the responsibility of the client or family to pay for "Late Cancel" and "No Call/No Show" appointments.

____________________________________ ____________________________

Signature of Client or Parent/Legal Guardian Date

RELEASE OF INFORMATION

(Only one agency or individual listed per release)

Client's Name: ________________________________ DOB: ______________

Parent/Guardian's Name: ____________________________ Date: ______________

I, the undersigned, hereby give consent to Common Threads Family Resource Center to correspond with

Client's Primary Physician:____

____

Regarding my (or my child's) care and treatment at Common Threads. This release allows for verbal and written exchange of information regarding:

___ Intake Interview
___ Progress Notes/ Therapist Notes
___ Treatment Planning
___ Discharge Summary
___ Other ______________________________

This release is valid until ______________ (one year unless a date is specified).

A photocopy of this authorization is valid as the original.

I, the undersigned, have the right to revoke this consent at any time in writing.

____

Signature of Parent/Legal Guardian   Date

RELEASE OF INFORMATION

(Only one agency or individual listed per release)

Client's Name: ______________________________________ DOB: _______________

Parent/Guardian's Name: ______________________________ Date: _______________

I, the undersigned, hereby give consent to Common Threads Family Resource Center to correspond with

____

____

Regarding my (or my child's) care and treatment at Common Threads. This release allows for verbal and written exchange of information regarding:

___ Intake Interview
___ Progress Notes/ Therapist Notes
___ Treatment Planning
___ Discharge Summary
___ Other ______________________________

This release is valid until _______________ (one year unless a date is specified).

A photocopy of this authorization is valid as the original.

I, the undersigned, have the right to revoke this consent at any time in writing.

____

Signature of Parent/Legal Guardian Date

Waiver of Liability Release

Client Name: ____ DOB: ________________

Parent/Guardian Name: ______________________________ Date: ________________

As a client/student (or parent of a client/student) in educational and/or therapeutic programs at Common Threads Family Resource Center:

Common Threads Family Resource Center
5979 Siggelkow Road
McFarland, Wisconsin 53558

Common Threads Family Resource Center
4800 Ivywood Trail
McFarland, WI 53558

I hereby release the representatives, agents, supervisors, and board of directors of all liability for damages or injuries sustained by myself or my child while participating in these programs.

This release is valid for one year or until I (or my child) exit the programs at Common Threads (which ever event happens first).

A photocopy of this release is valid as the original.

I, the undersigned, have the right to revoke this consent at any time in writing.

____
Signature of Parent/Legal Guardian   Date

Prescription For Clinical Services

Date: ______________

Name of Physician: __________________________

Physician's NPI #: ___________________________

Name of Patient/Client: _______________________

Patient/Client DOB: __________________________

I, ____________________________________, verify that the above patient is eligible for clinical services at Common Threads Family Resource Center. Common Threads Family Resource Center offers clinical services for Mental Health, Occupational Therapy, and Speech and Language Therapy. This form serves as a prescription for the following:

MH _____

OT _____

SLP _____

Please list any and all diagnoses on the attached form below.

This form is valid until _____________ (One year unless a date is specified).

Signature of Physician _____________________________

For your convenience, listed below are diagnoses of individuals who are typically referred to Common Threads Family Resource Center. Please list any additional diagnosis, not listed below, in the boxes that are marked "OTHER".

Please Check	ICD-10 Code	Diagnosis
	F33.1	Major depressive disorder, recurrent, moderate
	F34.81	Disruptive mood dysregulation disorder
	F39.0	Unspecified mood [affective] disorder
	F40.10	Social phobia, unspecified
	F41.1	Generalized anxiety disorder
	F41.9	Anxiety disorder, unspecified
	F42.9	Obsessive-compulsive disorder, unspecified
	F43.20	Adjustment disorder, unspecified
	F63.81	Intermittent explosive disorder
	F88.0	Other disorders of psychological development
	F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive
	F90.2	Attention-deficit hyperactivity disorder, combined type
	F90.9	Attention-deficit hyperactivity disorder, unspecified type
	G47.9	Sleep disorder, unspecified
	K59.00	Constipation, unspecified
	R20.9	Unspecified disturbances of skin sensation
		Other:
		Other:
		Other:
		Other:
		Other:

Does this individual have an Autism Spectrum Disorder Diagnosis? YES or NO

5979 Siggelkow Road, McFarland, Wisconsin 53558 (608) 838-8999 www.commonthreadsmadison.org

Medical Treatment Release Form

To Whom it May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed.

Name of Client: ______________________ DOB: ______________________

Primary Contact: ______________________ Relationship to you: ______________

Home Phone: ______________________ Cell Phone: ______________________

Emergency Contact: ______________________ Relationship to you: ______________

Home Phone: ______________________ Cell Phone: ______________________

Primary Physician: ______________________ Phone: ______________________

Address: ____________________________________ City: ______________

List allergies, medications, contract, or other pertinent comments:

____

____

____

Health Insurance Data:

Company: ______________________ Policy #: ______________________

Group #: ______________________ Contact: ______________________

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: ______________________ Signed: ______________________
(Parent or Guardian)

Common Threads Transportation Policy

Client's Name: ______________________________ DOB: ______________________

Parent/Guardian's Name: ________________________ Date: ______________________

Common Threads Family Resource Center requires that an adult be present for drop off and pick up of all clients. Clients arriving early to sessions will need to be supervised by an adult within our waiting room spaces. All transportation is expected to be on time for pick up, as Common Threads is not able to supervise clients as this may compromise the treatment of the next client.

Occasionally, clients will request to use public transportation that does not allow for supervised transitions into and out of the buildings or supervision within the waiting rooms inside of our buildings. All public transportation drop-offs and pick-ups for clients whom are minors will be reviewed for appropriateness on a case by case basis. These clients will need to remain stable and show independence for this transportation option to be considered. Please make sure that you provide your clinician or team leader adequate time to review your logistical plan before setting up this type of transportation. Once a transportation plan is approved, it must be agreed upon and maintained by all parties involved.

Common Threads Family Resource Center does not arrange transportation for Clients or Students.

It is the responsibility of the client or client's family to cancel all transportation to and from Common Threads Family Resource Center in the event of an absence.

We strictly adhere to this transportation policy. Failure to comply with the following could result in loss of service.

___________________________________ ________________________

Signature of Client or Parent/Legal Guardian Date

Informed Consent

Photographs, Film and Recording

Client's Name: ____________________________ DOB: ___________________
Parent/Guardian's Name: ___________________ Date: ___________________

Photographs, videos and audio recordings may be used for internal educational, therapeutic and/or training purposes. In most cases this material is confidentially disposed of. Occasionally retaining the record is beneficial to the client. In such cases, the record will be saved according to HIPPA protocol.

I hereby authorize Common Threads to photograph, film or record me/my child for the above reasons.

A photocopy of this authorization is valid as the original.
This release is valid until ___________________ (one year unless a date is specified).

I, the undersigned, have the right to revoke this consent at any time in writing.

_____________________________ ___________________
Signature of Student/Client or Parent/Legal Guardian — Date

Optional Photo/Video Release

Please initial any of the following that apply:

___ For social purposes, I authorize Common Threads to share with other school families photos and videos that include my child.

___Other ____

_____________________________ ___________________
Signature of Student/Client or Parent/Legal Guardian — Date

Policies and Procedures
Confidentiality

Client Name: ____ DOB: __________________

Parent/Guardian's Name: ______________________________ Date: __________________

All agency case material is kept strictly confidential. Periodically it may be helpful to consult with other professionals and agencies for the on-going management of therapy, and we will request written consent for an exchange of information. The only exceptions to the above policy relate to the following obligations under Wisconsin Law:

- Psychotherapists, Occupational Therapists, Speech Therapists, and Therapeutic Facilitators are legally responsible to report to authorities when they feel an individual may cause harm to self or others.
- Psychotherapists, Occupational Therapists, Speech Therapists, and Therapeutic Facilitators are required, by law, to report any evidence of child abuse.

I have read and understand the Common Threads Family Resource Center's Policies and Procedures and I have received a copy of the HIPAA notice of privacy practices.

____

Signature of Client or Parent/Legal Guardian Date

5979 Siggelkow Road, McFarland, Wisconsin 53558 (608) 838-8999 www.commonthreadsmadison.org

COMMON THREADS EMERGENCY ON-CALL POLICY

What is an Emergency?

A mental health emergency is an emotional or behavioral crisis that warrants same day attention by a mental health professional. This may include, but is not limited to, significant changes in behavior that are not characteristic of a person, the presence of disruptive symptoms that interfere with the responsibilities of daily living, direct or indirect expressions of the intent to harm self or others, or the experience of trauma.

Daytime Emergency Services

Common Threads Family Resource Center provides emergency services from 8 am to 4 pm during summer session and from 8 am to 6 pm during fall, winter, and spring sessions. Consumers may call Common Threads Family Resource Center at 608-838-8999 and ask to be scheduled for an emergency appointment or request to speak with the on-call clinician. If the clinician is not available, s/he will typically return calls on the hour. Clinical staff responds immediately to imminent crises.

After-hours Emergency Services

Consumers in crisis after 6pm or on weekends:

If the consumer is experiencing a mental health emergency 911 should be called to support and assist the individual in crisis.

If the consumer is a currently enrolled client of Community Partnerships-Children Come First Program and is experiencing a mental health emergency during hours that Common Threads Family Resource Center is closed these individuals should call Community Partnerships on-call line directly at 250-6634 and speak with the On-Call Staff member.

All other Common Threads Clients experiencing a mental health emergency during hours that Common Threads Family Resource Center is closed should contact the on-call Clinician Dane County Mental Health Center at 608-280-2600.

Additionally, any client in crisis can contact the National Suicide Prevention Hotline at 1-800-273-8255.

CLIENT RIGHTS

As a client (or parent of a client) receiving treatment from Common Threads for mental illness or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61(1) and HFS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your (or your child's) treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You (or your child) may not be filmed, taped or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.
- You must be allowed to participate in the planning of your (or your child's) treatment and care.
- You must be informed of your (or your child's) treatment and care, including alternatives to and possible side effects of treatment.
- No treatment or medication may be given to you without your written, informed consent, <u>unless</u> it is needed <u>in an emergency</u> to prevent serious physical harm to you, your child, or others, or a <u>court orders it</u>. [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute Sec. 51.30 and HFS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30 Wis. Stats., and/or HFS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURT

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way by for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or at any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (optional)

- You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation- Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The Client Right's Specialist for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.
- If you agree with CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Board of Directors Decision

- If the grievance is not resolved by the CRS's report, the Board of Directors or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, DDES PO. Box 7851, Madison, WI 53707-7851.

Final State Review

- Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Disability and Elder services or designee. Send your request to the DDES Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by Common Threads Family Resource Center.

YOUR CLIENT RIGHTS SPECIALIST IS:

Name: Ellen Eggen, MS LPC ATR-BC

Address: 5979 Siggelkow Rd.

McFarland, WI 53558

Phone: 608.838.8999

Note: There are additional rights within sec. 51.61(1) and HFS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to inpatient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or HFS 94, Wisconsin Administrative Code is available upon request.

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Common Threads Family Resource Center ("CTFRC") is required by applicable federal and state law to maintain the privacy of your medical information. CTFRC is also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. CTFRC must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 4/14/2003, and will remain in effect until we replace it.

CTFRC reserves the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. CTFRC reserves the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new one available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USE AND DISCLOSURE OF MEDICAL INFORMATION

CTFRC may use and disclose your medical information about you for treatment, payment, and health care operations. For example:

To Provide Treatment: CTFRC may use your health information to provide care to you and disclose health information to others who provide care to you. CTFRC also may disclose your health care information to individuals outside of CTFRC involved in your care including family members and other health care professionals. We may need your written permission to disclose information taken from your mental health treatment records to provide treatment.

To Obtain Payment: CTFRC may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal Privacy Rules so they can obtain payment. We may need your written permission to disclose information taken from your mental health treatment records for payment purposes.

To Conduct Health Care Operations: CTFRC may use and disclose your medical information in connection with our health care operations. Health care operations include:

- quality assessment and improvement activities
- reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities
- medical review, legal services, and auditing, including fraud and abuse detection and compliance
- business planning and development
- business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

CTFRC may disclose your medical information to another entity which has a relationship with you and is subject to the federal Privacy Rules, for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professional, or detecting or preventing health care fraud and abuse.

CTFRC may need your written permission to disclose medical information or information taken from your mental health records for health care operations.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To Your Family and Friends: With your written permission, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

CTFRC may use or disclose your name and location (and, with your written permission, general condition or death) to notify, or assist in the notification of (including identifying or locating), a person involved in your care. If you have not previously given us written permission for such uses or disclosures, CTFRC will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your name and locations based on our professional judgment or whether the disclosure would be in your best interest.

CTFRC will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of medical information. CTFRC may not disclose confidential medical information or any information taken from mental health treatment records in these circumstances without your written permission or any information taken from mental health treatment records in our facility directories without your written permission.

Health Related Services: CTFRC may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. With your written permission, we may disclose your medical information to others involved in providing health related services to you.

Public Benefit: CTFRC may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law
- for public health activities, including disease and vital statistic reporting, child abuse reporting and FDA oversight
- to report adult abuse or neglect
- to health oversight agencies
- in response to court and, in some circumstances, administrative orders and other lawful processes
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person
- to coroners and medical examiners
- to organ procurement organizations
- to avert a serious and imminent threat to health or safety
- in connection with certain research activities
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities
- to correctional institutions regarding inmates and
- as authorized by state worker's compensation laws

You may be able to opt out of use of disclosure of your medical information for (a) research purposes or (b) pursuant to a written request from a government agency, unless the disclosure is required by law.

CTFRC may not disclose certain confidential medical information or mental health treatment records for certain of these purposes without your written permission, unless required by law.

Disaster Relief: CTFRC may use or disclose your name and location to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. CTFRC may not disclose confidential medical information (except in response to a written request from a government agency) or any information taken from mental health treatment records in these circumstances without your written permission.

INDIVIDUAL RIGHTS

Access: You have the rights to look at or get copies of your medical information, with limited exceptions. You may request that CTFRC provide copies in a format other than photocopies. CTFRC will use the format you request unless we cannot practicably do so. **(You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, CTFRC will charge you $0.50 for each page or $10 per hour for staff time to copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, CTFRC will charge a cost-based fee for providing your medical information in that format. If you prefer, CTFRC will prepare a summary or an explanation of your medical information for a fee. Contact CTFRC using the information listed at the end of this notice for a full explanation of our fee structure).**

Disclosure Accounting: You have the right to receive a list of instances in which CTFRC or our business associates disclosed your medical information for purposes, other than treatment, payment, health care operations for which we have written permission, and certain other activities, since April 14, 2003. CTFRC will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information disclosed, the reason for the disclosure, and certain other information.

If you request a disclosure accounting more than once in a 12-month period, CTFRC may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. CTFRC is not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **(Any agreement CTFRC may make to a request for additional restrictions must by in writing signed by a person authorized to make such an agreement on our behalf. CTFRC will not be bound unless our agreement is so memorialized in writing.)**

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. **(You must make your request in writing, and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location you want.)** CTFRC must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that CTFRC amend your medical information. **(Your request must be in writing, and it must explain why the information should be amended.)** CTFRC may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If CTFRC denies your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept you request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact CTFRC using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact CTFRC using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision CTFR made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have CTFRC communicate with you by alternative means or at alternative locations, you may complain to CTFRC using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. CTFRC will provide you with the address to file your complaint with a U.S. Department of Health and Human Services upon request.

CTFRC supports your right to the privacy of your medical information. CTFRC will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Joan Hopwood-- Business Manager

Telephone: 608-838-8999

Fax: 608-838-8988

E-mail: info@commonthreadsmadison.org

Address: 5979 Siggelkow Rd McFarland, WI 53558