Intake Form – Outpatient Substance Use Treatment

(Condensed – OASAS)

Program: _____ **Date:** _____ **Staff:** _____

Client Information

Legal Name: _____ **Preferred Name:** _____

Date of Birth: _____ **SSN:** _____

Legal Sex: ☐ F ☐ M ☐ Non Binary **Gender Identity:** _____

Sex Assigned at Birth: ☐ F ☐ M ☐ Intersex ☐ Prefer not to answer

Address: _____

City: _____ State: ____ ZIP: _____ County: _____

Phone: _____ ☐ OK to text **Email:** _____ ☐ OK to email

Language & Communication

Preferred Language: _____ **Interpreter Needed?** ☐ Yes ☐ No

English Fluency:
☐ Fluent
☐ Limited
☐ None

Race (check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Native American
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to answer

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Insurance: ☐ Medicaid ☐ Medicare ☐ Commercial ☐ Self-Pa **Policy Holder:** _____

Insurance Provider: _____ **Member ID:** _____

OASAS Required Information

Housing Status: ☐ Stable ☐ Temporary ☐ Homeless ☐ Controlled Environment

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Disabled

Legal Status: ☐ None ☐ Probation ☐ Parole ☐ Drug Court ☐ CPS

Veteran Status: ☐ Veteran ☐ Not a Veteran **Branch of Service (if applicable):** _____

Primary Care Physician: _____ **Phone #:** _____

Consents & Acknowledgment

☐ HIPAA Notice of Privacy Practices Received

☐ 42 CFR Part 2 Confidentiality Explained

☐ Client Rights & Program Rules Received (OASAS)

I certify that the information provided above is accurate.

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Cayuga Addiction Recovery Services (CARS)
An Affiliated Member of Cayuga Health | Centralus Health

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION REGARDING PERSONS WITH SUBSTANCE USE DISORDER FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO)

PATIENT'S LAST NAME	FIRST	M.I.
MRN #	DOB	
LOCATION: Ithaca Op/OTP		

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Evaluation, psychosocial summary, presence in treatment (including admission and discharge dates), diagnosis (brief description of progress and prognosis), results of urine screens and alco-sensors, treatment plan, discharge summary and any other information as required for treatment, payment or healthcare operations purposes.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

To allow for coordination of treatment, payment and healthcare operations on behalf of the patient.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Name: Primary Addiction Counselor, or designee **Facility: Cayuga Addictions Recovery Services (C.A.R.S)** **Address: 334 W. State Street Ithaca, NY 14850** **Phone: (607) 273-5500** **Fax: 607-273-1277**	**The patient's treating providers, health plans, third-party payers, and people helping to operate this program.**

This authorization will not expire, unless revoked at the request of the undersigned.

I, the undersigned, have read the above and authorize the staff of the disclosing/ releasing facility name to disclose/ release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance on it. This consent shall not expire. I also understand that any disclosure/ release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R Pts. 160 &164; and that redisclosure of this information by the recipient may no longer be protected under Part 2 regulations.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ _____

Patient Signature and Date **Legal Authorized Representative Signature and Date**

NOTICE (42 CFR § 2.32(a)(1)) This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)	_____ (Signature of Parent/Guardian)
_____ (Print Name of Patient)	_____ (Print Name of Parent/Guardian)
_____ (Date)	_____ (Date)

NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   _____ If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

   _____ If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information:
   Cayuga Addiction Recovery Services, 334 W. State St., Ithaca, NY 14850

6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged:

   NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203

   I authorize the above listed Entity to inform the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my enrollment in this treatment program so that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and OASAS relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services.

7. The Purpose of this disclosure is to comply with implementation of New York's Medicaid redesign initiative and to comply with mandatory federal reporting requirements. By accepting the information covered by this consent into the NYS OASAS Client Data System, NYS OASAS acknowledges that this information may not be redisclosed per 42 CFR 2.32 – Prohibition on redisclosure.

8. My health information may be disclosed for a period of three (3) years from the last date of service, or until revoked.

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

Cayuga Addiction Recovery Services

Understanding of Fee Scale Agreement

I have been notified of the following:

- Although your Medicaid or Insurance states that this service is covered, they may choose to refuse payment at some point for the following reasons:
  - You lose your benefits
  - Your benefits change

- If your Medicaid or Insurance refuses payment, you will be required to pay for each services provided that insurance denies and be expected to pay for each service after that.

- You can apply for a sliding scale fee to reduce this amount in case of Insurance or Medicaid denials, but you must bring us proof of income to apply for this.

It is your responsibility to bring this income verification and apply for a sliding scale fee if you wish to have one.

_____	_____	_____
Client Name (Print)	**Client Signature**	**Date**

Financial Intake Form

Name: _____ **DOB:** _____ **SSN:** _____

Billing Address: _____

The Cayuga Addiction Recovery Services (CARS) Outpatient and Opioid Treatment Clinic is a fee for service program. We will charge a fee for each service provided based on our current fee schedule. Payment for services rendered by Cayuga Addiction Recovery Services is the responsibility of the client or legal guardian. Please be advised that you will be asked to provide payment before each service.

We accept Medicaid and other third-party insurance and will bill these carriers directly for our services. Clients may be held responsible for any fees not covered by third party payers. Individuals who do not have Medicaid or Insurance coverage and are unable to pay the fee may apply for a sliding scale fee. To apply for a sliding scale fee, you must complete the appropriate application and provide us with household income information necessary to verify your current financial situation.

Cayuga Addiction Recovery Services accepts the following payment methods: Visa, MasterCard, Discover, cash, and personal check. Please note there is a $35.00 fee on all returned checks.

Clients who receive services but do not provide things such as; insurance information, income information, fee scale payment, or full service payment will be at risk of involuntary discharge from the program.

Below are several payment options, please select one of them

__ I will pay for each service provided to me. I understand that fees charged to me will be based on the current CARS fee schedule.

__ I am Medicaid eligible and agree to bring my benefit card with me to each appointment. I understand that if my benefits are discontinued for any reason, I will be financially responsible for all services provided to me. (Attach copy of benefit card)

__ I wish to apply for Medicaid benefits. I will provide verification of applying for Medicaid in the next two weeks from today's date to the Cayuga Addiction Recovery Services office staff. I understand that if I fail to complete the application process or am ineligible for benefits, I will be financially responsible for all services provided to me at full fee.

__ I have insurance and will provide all information necessary for Cayuga Addiction Recovery Services to bill for these services on my behalf. I understand that I may be held financially responsible for co-payments, deductibles, or fees for services not covered under my insurance policy. (Provide benefit card to front office staff)

__ I have a Medical Flexible Spending Plan, Medical Savings Account, or Healthcare Reimbursement Account to help cover the deductible on my health insurance plan.

__ I wish to apply for a sliding scale fee. I agree to complete an application for a sliding scale fee and will provide all documents requested, including income verification, to substantiate my need for a reduced fee. I understand that my financial situation will be re-assessed yearly, and I agree to advise Cayuga Addiction Recovery Services personnel any time my financial situation changes (i.e., new job, etc.). **I understand that if I fail to complete the application process, I will be charged full fee for all services.**

_____ _____

Client Signature **Date**

C.A.R.S.
CAYUGA ADDICTION RECOVERY SERVICES

Outpatient Program Client Handbook

Outpatient Staff Hours of Operation

Monday - Friday 7:30am-4:00pm

OTP DOSING HOURS

Monday- Friday 7:30am – 12:30pm

Saturday 8:00am – 12:30pm

AFTER HOURS CONTACT

If you have a medical emergency at any time

CALL 911 FOR ALL MEDICAL EMERGENCIES.

VISION, MISSION AND VALUES

BELONGING - We care about people and our relationships and demonstrate this by:

- Being compassionate to those we serve and with our co-workers.
- Collaborating to address challenges and collectively working toward solutions.
- Promising to give each other unconditional positive regard first.
- Asking rather than assuming.
- Paying attention to cultivating healthy relationships at work.
- Being pro-active vs. reactive with our co-workers, and as often as possible, with those we serve.
- Seeking to understand before being understood ourselves.

TRANSPARENCY - We tell the truth and demonstrate this by:

- Acting ethically and with integrity in all that we do and say.
- Telling the truth, as we know it, appropriately, and in a timely manner while also maintaining confidentiality of our clients and staff.
- Basing our decisions on facts, not rumor.
- Being constructive in sharing information and feedback.
- Owning, admitting, and being accountable for our personal actions
- Learning from our mistakes and each other in whatever ways are beneficial to ourselves and the agency.

KINDNESS - We care about people and our relationships and demonstrate this by:

- Being compassionate to those we serve and with our co-workers.
- Collaborating to address challenges and collectively working toward solutions.
- Promising to give each other unconditional positive regard first.
- Asking rather than assuming.
- Paying attention to cultivating healthy relationships at work.
- Being pro-active vs. reactive with our co-workers, and as often as possible, with those we serve.
- Seeking to understand before being understood ourselves.

STATEMENT OF VOLUNTARY PARTICIPATION AND CONSENT TO TREATMENT

I understand that my participation in the Cayuga Addiction Recovery Services is voluntary and that I am entitled to end my participation at any time. I also understand that if I am under the supervision of any referral source(s), Cayuga Addiction Recovery Services will notify these parties of my decision to terminate services provided there is a properly executed consent on file.

I give my consent to Cayuga Addiction Recovery Services, its staff, physicians, nurses and technicians to make examinations and render services to me which, in the opinion of Cayuga Addiction Recovery Services Staff, are deemed necessary or beneficial for my health and welfare while I am in the Cayuga Addiction Recovery Services.
It is agreed that partial or complete revocation of the above consent will not be effective until written notice of such revocation is delivered to the Cayuga Addiction Recovery Services director.

Consents

There are several consent forms that need to be completed prior to admission into OTP. Clients should know that many of these consents are required by the federal and state authorities governing opioid treatment. If you have any questions about any consent forms, please ask prior to signing them.

NOTICE TO CLIENT OF CONFIDENTIALITY REQUIREMENTS

THIS NOTICE DESCRIBES HOW CONFIDENTIAL INFORMAITON ABOUT YOU MAY BE COMMUNICATED INSIDE AND OUTSIDE OF CARS

The confidentiality of alcohol and drug abuse client's records maintained by this program is protected by Federal and State law and regulations. Generally, the program may not disclose that a client attends this program nor disclose any information identifying a client **without your written consent.**

CARS depends on various forms of communication to conduct its day-to-day business, including telephone, voicemail, facsimile, and e-mail. In recognition of the fact that these communications oftentimes contain confidential personal health information of CARS clients, the CARS Management Team has adopted the following procedural guidelines with respect to communication of confidential information within and among CARS programs and with outside sources.

Consistent with regulatory standards pertaining to the communication of confidential information between CARS staff members and outside sources, the following standards apply:
Communication of confidential information between CARS staff members and outside parties shall be subject to a "minimum necessary" standard. This standard means that people are to be given access to the minimum amount of information necessary to accomplish a given task or purpose.

Confidential information will be shared with parties outside CARS only with written consent from the client. (Exceptions to this standard include but are not limited to: the need to report a crime committed on program premises or against program personnel; to medical personnel in the event of a medical emergency; to report suspected child abuse or neglect; to report certain infectious diseases as required by state law; and disclosures allowed by a court order. Please see your primary counselor for further information about disclosures which can be made without client consent).

There are special cases in which your written consent may not be required in order to disclose your information. These exceptions include but are not limited to: the need to report a crime committed on program premises or against program personnel; to medical personnel in the event of a medical emergency; to report suspected child abuse or neglect; to report certain infectious diseases as required by state law; and disclosures allowed by a court order. Please see your primary counselor for further information about disclosures which can be made without client consent.
Other Exceptions:

- This may include intentions of leaving the premises under the influence of a psychoactive drug that poses a threat to the safety or welfare of self or others.

- Federal law and regulation do not protect any information about a crime committed by a client at the program or against any person who works for the program or about any threat to commit such a crime.

- Federal regulations do not prohibit any information about suspected child abuse or neglect from being reported under State law to appropriate Federal or State authorities in accordance with regulations.

- Pursuant to an agreement with a qualified service organization to obtain services such as financial or legal.

As an additional safeguard to protect confidential information, the following notice shall be attached to all written forms of communication (letters, reports, e-mails, faxes) from CARS that include confidential information:

"This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the confidentiality rules. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If you have received this communication in error, please notify the sender immediately and destroy the accompanying information."

HIV-related information

Under New York State law, HIV-related information can only be given to persons allowed to have it by law or allowed to have it by a release signed by the client. A client can request a list of people who can be given HIV-related information without a release form.
Confidential HIV-related information is any information indicating that you had an HIV-related test, have HIV-related illness or AIDS, HIV-related infection or any information which could reasonably identify you as a person who has had a test for, or has HIV infection.
(See 42 U.S.C. 2900dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 and 45CFR Parts 160 and 164 for Federal regulations; see New York Mental Hygiene Law section 23.05, Public Health Law Article 27-F, 10 NYCRR Part 63 and 14 NYCRR Parts 1070 and 1072).
Violation of the Federal or State law and regulations by a program is a crime. Suspected violations may be reported to appropriate Federal or State authorities in accordance with regulations.

If you experience discrimination because of release of HIV-related information you may contact the New York State Division of Human Rights at (212)87908624 or The New York City Commission of Human Rights at (212)566-5492. These agencies are responsible for protecting your rights.

These consents expire 60 days after discharge

Welcome to CARS Letter
Statement of Clients Rights
Notice to Clients Confidentiality Requirements
CARS Rules and Regulations
Statement of Voluntary Participation and Consent to Treatment
Policy for Collection of Urine Screen Samples
Questions/Comments/Concerns/Complaints
CMC Lab
Attendance Policy
Tobacco Free Client Agreement
Gambling Free Client Agreement
Communication of Confidential Information Between CARS Staff member to Outside Sources
Overview of CARS financial Policy and Expectations related to such

Any concern related to records or privacy rights may be referred directly to the Treatment Director, verbally, in writing, or by calling 607-273-5500.
A client may also contact the New York State Office of Alcoholism and Substance Abuse at 1-800-553-5790.

A client may also contact The Office for Civil Rights, U.S. Department of Health & Human Services at 212-264-3313/TDD 212-264-2355/Hotline 1-800-368-1019.

Clients will not be retaliated against for filing such a complaint.

STATEMENT OF CLIENTS' RIGHTS

1. Each client has a right to participate in the development of an individually designed plan of services that is based on their needs and includes goals that the client has agreed to work toward.
2. Each client has the right to considerate and respectful care.
3. Each client has a right to be free of personal involvement with any facility staff member.
4. Each client has a right to receive services from a staff that is competent, caring, and of sufficient number to provide adequate services.
5. Each client has a right to be treated in a way that recognizes and responds to their cultural identity and/or disability and/or sexual orientation and/or sex.
6. Each client has the right to know the name of the primary counselor responsible for their care and the name of any other person providing care to them.
7. No client shall be treated by any staff member whose work performance is impaired.
8. Each client has a right to obtain current information from their primary counselor concerning diagnosis and treatment, in terms the client can reasonably be expected to understand.
9. Each client has a right to know the facility rules that apply to his or her conduct.
10. Each client has a right to receive services in a physical environment that is safe, sanitary, reflective of human dignity, conducive to effective treatment and which appropriately safeguards the privacy and confidentiality of all client-staff interactions.
11. No treatment requiring the order of a physician shall be given to a client, except upon the prior written order of a physician, based on a personal examination.
12. Each client has a right to examine and receive an explanation of their bill, regardless of source of payment.

13. Each client has the right to inspect and request a copy of their own records, except to the extent that the information contains psychotherapy notes or information that is being compiled for use in a civil, criminal, or administrative proceeding, or in other limited circumstances related to health and safety of the client or other persons. The request must be put in writing to the facility director. A nominal fee may be charged for copying, and CARS is required to respond to the request in thirty days. CARS will put all denials of access to records in writing.
14. Each client has a right to amend their own records by putting a request in writing to the facility director. CARS must respond to the request within sixty days. A request to amend a record may be denied if CARS was not the originator of the information, the information is not part of the designated record, the record is not available for inspection due to involvement with a civil, criminal or administrative proceeding, or the record is determined accurate and complete. CARS will put all denials of amendments to records in writing.
15. Each client has the right to request restrictions on certain uses and disclosures of treatment information by putting their request in writing to the facility director. CARS is not required to agree to any restrictions a client requests, but if there is agreement, CARS is bound by that agreement and may not use or disclose any information which the client has restricted, except as is necessary in a medical emergency.
16. Each client has a right to request an account of disclosures of their treatment information made during the six years prior to the date of the request by putting their request in writing to the facility director. The accounting must be in writing and include disclosures made related to research, pursuant to court orders, to report child abuse and pursuant to qualified service. CARS must respond in writing to the request within sixty days and a nominal fee may be charged for any accounting of disclosures provided beyond a 12-month period.
17. Each client has a right to request, in writing, to the facility director to receive communications of protected treatment information by alternative means or at alternative locations, such as, other than a client's home.
18. Each client may object to conditions at the facility or have concerns or appeals related to the above-described client rights. Each client has a right to a prompt, reasoned response from facility management. Clients may lodge such objections or concerns verbally or in writing with the facility director who will attempt to resolve the problem immediately by working with facility personnel. A client may also place their complaint in the client suggestion box that is periodically checked by the Treatment Director. The Treatment Director will attempt to resolve the complaint and, in the event, that they are unsuccessful, the complaint will be referred to the agency's management team for further review and intervention.

I understand that my alcohol and drug treatment records are protected under the Federal Regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Pts. 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

CAYUGA ADDICTION RECOVERY SERVICES RULES AND REGULATIONS

1. Clients are required to pay for services at the beginning of each session. If you have a co-pay or fee, you are responsible for payment of that co-pay for each service received (assessment session, group session, individual session, etc.). Payment may be made with cash, check

(made out to Cayuga Addiction Recovery Outpatient Services), money order, or credit card. Payments may be made at the receptionist's desk. (See also CARS OTP Financial Policy)

2. Any client who appears to be under the influence of any mind-altering substances will be asked to meet with a member of the clinical team to determine the need for any additional services including referral to detox, referral to the medical provider, or any additional help needed. If there are any consents signed while the client appears under the influence those consents will be reviewed at the next session where the client appears stable and not impaired.
3. No firearms, knives, or other weapons are allowed on the premises. Necessary items related to work duties such as knives that could be used as a weapon, must be left in your personal vehicle, or with the receptionist while you are in session, with approval from the clinical director.
4. The possession or sale of illicit substances on the CARS premises is a crime and will not be tolerated.
5. CARS staff are not permitted to meet with or socialize with clients outside the office.
6. Clients should arrive promptly for all scheduled sessions including individual and group. If you are going to be late due to unforeseen circumstances, please notify your primary counselor or the front office staff as soon as possible. Clients will be allowed to enter group no later than 10 minutes past the start time of their scheduled group.
7. To obtain the greatest benefit from treatment, clients are expected to attend all scheduled sessions. The following are considered acceptable excuses for missing an appointment: a signed medical excuse from one's physician or dangerous driving conditions due to a storm. In addition, missing an appointment could result in consequences with your referral source and/or additional clinical interventions as determined by the clinical team or program supervisor. Rescheduling of appointments must be arranged with the client's counselor.
8. Upon entering treatment all clients are expected to actively engage in carrying out the activities of their individualized treatment plans.
9. No form of discrimination, threats, or violence to CARS staff or other clients is acceptable. Such actions could possibly result in meeting with the leadership team, discharge from the program, etc.

Questions/Comments/Concerns/Complaints

In order to continue to provide quality substance use disorder treatment, Cayuga Addiction Recovery Services is interested in any questions, comments, concerns, or complaints you may have. You can Provide you input by:

- Speaking with your Counselor
- Speaking with the Program Director
- Filling out a suggestion/complaint form (located in the reception area of the clinic, front office staff have the forms) and placing it in the suggestion/complaint box, which is checked weekly by a member of the Leadership Team.
- Filling out a suggestion/complaint form and mailing it to:

  Cayuga Addiction Recovery Services Incident & Complaint Review Committee

  PO Box 789

  Ithaca, NY 14851

- Contact the New York State Office of Alcoholism and Substance Abuse at:

  Web: www.oasas.ny.gov/PA/index.cfm

  E-mail: PatientAdvocacy@oasas.ny.gov

  Phone (800)553-5790

- Contact the Justice Center Vulnerable Persons' Central Register at: (855)-373-2122

Toxicology

CARS will conduct toxicology tests as often as necessary and clinically appropriate. Toxicology screens are used for multiple reasons such as to monitor progress in treatment, adherence to prescribed medication, take-home eligibility, etc.

Policy for Collection of Toxicology Samples

1. All clients who come to the agency regarding their own substance use will be expected to provide on-site toxicology samples at the time of their first appointment as part of the assessment process and is a requirement to engage in services.
2. Clients will also be expected to provide samples on-site for random testing during their treatment. The frequency of the testing will depend on the program the client is engaged in, medications prescribed, clinical concerns, medical concerns, legal purpose, etc.
3. Any client participating in local treatment courts shall be tested, at a minimum, once every 14 calendar days.
4. Confirmation testing is available, should a client desire to challenge a positive test result.
5. If a client is unable to provide a monitored urine sample the client will be required to provide medical documentation to the Opioid Treatment Program Leadership as to why they are unable to provide a monitored urine sample. If the client is unable to do so they will receive assistance in a referral to another provider or to medical services.

CARS Tobacco Free Client Agreement

As a client of the CARS, I understand the program is committed to working towards a reduction in substance use, illness, and death caused by tobacco products through the establishment of a tobacco free environment and tobacco free services.

I agree to the following:

1. I will not use any type of tobacco products while on the CARS facility premises, which include the sidewalks surrounding the outpatient building and parking lot.
2. I agree and understand that specific goals and objectives will be included in my treatment for tobacco use, if appropriate, and that if I do not make progress on those goals, I will be out of compliance with my treatment recommendation.

3. I agree that I will not bring tobacco products, including lighters, snuff, chewing tobacco, cigars, cigarettes, e-cigarettes, vapors, and other smoking paraphernalia to any CARS sites (including the residential facility (RARC).
4. I understand that if I violate the CARS tobacco free policy (and this agreement) my treatment plan will be reviewed, and the issues may be addressed through a progressive case review process which may result in discharge from treatment services.
5. I understand that if tobacco products are used outside of the program site, I am obligated to take measures to remove the odor or evidence of smoking from my person before entering the outpatient site (i.e., washing hands, brushing teeth, using mints or alcohol-free mouthwash, etc.)
6. I agree to inform all visitors or family members of the tobacco free policy (including bringing tobacco products into the outpatient facility) and that visitors who use tobacco products on the site will be asked to leave.

CARS Gambling Free Client Agreement

As a client of the CARS clinic, I understand the program is committed to working towards a reduction in use, illness, and negative circumstances caused by gambling products through the establishment of a gambling free environment and by making gambling treatment services available.

I agree to the following:

1. I will not use any type of gambling products while on the CARS outpatient clinic premises, which include the sidewalks surrounding the outpatient building and parking lot.
2. I agree and understand that specific goals and objectives will be included in my treatment plan related to gambling, if appropriate, and that if I do not make progress on those goals, I will be out of compliance with my treatment recommendation.
3. I agree that I will not bring gambling products, including lottery tickets, scratch-off tickets, and other gambling paraphernalia to any CARS sites, including outpatient and Residential Addiction Recovery Center (RARC).
4. I understand that if I violate the CARS gambling free policy (and this agreement) my treatment plan will be reviewed, and the issue may be addressed through a progressive case review process which may result in termination from treatment.
5. I understand that if gambling products are used outside of the program site, I am obligated to take measures to not show such items to others in the clinic
6. I agree to inform all visitors/family members of the gambling free policy (including bringing gambling products onto the outpatient clinic premises) and that visitors who use gambling products on the site will be asked to leave.

No-Show Appointment Policy

It is our belief that our clients will more quickly gain the tools needed to be successful in their recovery by attending services regularly and frequently. Please make sure your contact information is updated so our staff can reach you to schedule your services and provide you with

important updates. Your contact information can be updated with the front office or your counselor. It is important to attend your services in a timely manner so you can receive the support, if you feel you cannot attend your appointment, please call within 24 hours of your appointment to cancel or reschedule. This will allow others who need services to schedule an appointment in that place.

A No-show for a scheduled service is defined as a scheduled services that a client does not come in for, cancels less than 24 hours prior, or arrives more than 15 minutes late and is unable to be seen.

1 No-Show Appointment

If you miss 1 appointment the next appointment will be scheduled for a maximum of a 30-minute duration. At that time, you will be notified that it is important for you to keep your appointment times and that another missed appointment will continue to limit the duration of your sessions.

2 consecutive No-Show Appointment

If you miss two consecutive appointments the next appointment scheduled will be for a maximum of a 15-minutes. You will also be informed that 3 No shows in a row will result in not being able to schedule an appointment in advance, and you will have to come into the building, and meet with a clinician that has an opening to re-establish scheduled services.

3 consecutive No Show Appointment

If you have 3 consecutive missed appointments, you will no longer be able to schedule your appointments a head of time. Your clinician will inform you of open times they might have during in the future, and you can show up as a walk-in appointment around those times. This may cause additional wait times if there are scheduled appointments. To be able to return to scheduling an appointment you will have to show up two times consecutively to attend a service. Continued missed appointments and lack of engagement in services could lead to discharge.

Disruption of Services- If you have a back balance from co-pays or fees for services that exceed $75 dollars or more this could also cause a disruption in your ability to attend services. This can be resolved by pay 50% of your back balances or setting up an approved payment account with the front office manager.

Termination of Services - If you fail to follow the attendance policy and/or have no face-to-face contact with the clinical or medical staff in over 60 days your case can be closed due to non-compliance, and it will be recommended that they return to treatment when they are ready to engage.

How to Sign up for Zoom to receive Telepractice Services

Signing up and activating your Zoom Account

Joining an existing account

If you are being invited to an existing account, you will receive an email from Zoom (no-reply@zoom.us). Once you receive this email, click **Accept the Request**.

Accepting the invite to the other account will transfer your profile details (name, profile picture, time zone, etc.), scheduled meetings and webinars, cloud recordings, IM history, contacts, and settings, but will not transfer any reports. It is advised that you access and download any reports you may need before accepting the invite. You have 30 days to accept the invite before it expires.

Creating your own account

To sign up for your own free account, visit zoom.us/signup and enter your email address. You will receive an email from Zoom (no-reply@zoom.us). In this email, click **Activate Account**.

Signing into your Zoom account on the web

You can sign into your Zoom account on the web at any time, at zoom.us/sign-in. Once you're logged in, use the panel on the left side to navigate the Zoom web portal. You can update your profile, schedule a meeting, edit your settings, and more.

Updating your profile

You can update your profile by adding a profile picture, set your time zone, update your password and more. To access your Zoom profile, sign into the Zoom web portal and click Profile

If you need any assistance with signing up or troubleshooting access to telepractice services please contact CARS staff.

Text Message Disclosure

To assist in helping clients make their scheduled appointments at CARS we send reminders through text message to clients who provide their mobile numbers. It is the client's responsibility to inform and provide updated mobile numbers should it change as CARS is not responsible for making those changes without notification from the client.
Clients can opt out of this service at any time by informing the front desk, in person, of their desire to do so. After an in-person notification the front office staff will update the client's record instantly to reflect the desired change.

CARS Financial Policy

Each client that comes to CARS is responsible for providing a copy of their insurance card upon their initial appointment, as well as notifying front office staff of any updates or changes to their current insurance plan. The client is responsible for any co-pay and/or deductibles associated with their insurance provider.
If the client does not have insurance, or if the client is unable to pay the fees associated with their insurance plan, the client will be offered a sliding fee scale based on their income. If the fee assigned creates a financial hardship for the client, the client can utilize the appeal process to have their fee reduced. The client's ability to pay will be reassessed on a quarterly basis or at any time a client's personal financial situation changes and the fee scale will be adjusted accordingly.
If a client refuses to use the insurance benefits available to them or does not provide income verification to establish a sliding-fee scale, they will be responsible for paying the full fee for each service.

Non-payment of the fee, where the ability to pay exists, becomes a treatment issue when the client has failed to make payment after:

• Three consecutive visits have not been paid, or
• A total of five visits have not been paid, or
• A client has a balance of at least $75 due to not paying their fee or co-pay in full

When these situations arise, the client will not be eligible to receive services until a minimum of 50% of their back balance is paid. If the client provides evidence of extenuating circumstances of why this would not be feasible, a review of the client's personal financial situation is made. The review is conducted within seven business days by the client's Primary Counselor, Director of OTP and Outpatient Services and the OTP Supervisor of Administration and Facilities to arrive at a mutually agreeable payment plan. If the client fails to comply with the terms of the agreement in the following weeks, further intervention by the leadership team may be expected and could include discharge from CARS.

OTP Program Specific Information

What is OTP?

OTP stands for Opioid Treatment Program, which administers medication assisted treatment (Suboxone, Methadone), along with a comprehensive treatment plan including individual and group treatment sessions. Both aspects of treatment are equally important for sustained abstinence.

Consideration of Induction Process

OTP consideration is up to a three-day process to ensure clinical and medical appropriateness for the program. It is important that you are on time and keep ALL appointments through this process. There will be no exceptions.

CARS OTP- Day 1

- You will review and sign necessary documents, complete a clinical assessment and a urine drug screen with a counselor to begin the process of determining your appropriateness for OTP admission.

CARS OTP- Day 2

- You will complete an interview with the OTP Nurse, in addition to a lab blood draw, EKG, urinalysis, breathalyzer, and a pregnancy test for women.

Be sure to bring a list of current medications and medication bottles; your primary care physician contact information; your psychiatrist contact information (if applicable); and pharmacy contact information. Be prepared to sign releases for all current medication providers to facilitate continuity of care. If you are pregnant be prepared to sign releases for your OB-GYN to facilitate continuity of care.

CARS OTP- Day 3

- You will complete a history and physical with the CARS OTP Provider. At this appointment the decision of induction into the program will be made. If appropriate for admission you will receive your first dose of medication on this day.

Medication Policy

If a client is being prescribed a medication from an outside source, the client must sign consent for that provider, so the CARS OTP prescriber may coordinate care.

Individual Identification Card

On induction day you will receive a photo identification card with your name, and date of birth. Every dosing day, when you check in you will receive your identification card before you receive your medication dose. Before receiving your dose of medication, you will be asked to give the card to the nurse at the dosing window.

Central Registry

OTPs utilize a "Central Registry System" that ensure clients are not enrolled in more than one OTP at a time. Prior to your admission, CARS will contact the Central Registry and provide your name, to ensure you are not already enrolled in an OTP.

OTP Medication Administration Scheduling

Medication administration is scheduled from Monday-Friday from 6:15 am -11:30 am and Saturday from 8:30 am-12:30 pm. You will receive a single dose to take home to cover Sundays and federal holidays (see below). You will not be able to receive your medication outside of these hours. You will coordinate with your counselor to decide a dosing schedule that is best for you depending on work schedules and other responsibilities. **Clients are scheduled in 60-minute blocks of time, and you will only be able to receive your dose within that block of time.** For example, if you are scheduled in the 8:00-9:00 block of time, you must present to OTP to be dosed within that hour. Clients requesting to dose at a specific time must provide documentation supporting the request (i.e., work schedule).

You will be asked to bring in your work schedule if you wish to request a specific dosing time.

Medication Administration for Sundays and Holidays

You will be provided with extra medication if your regular OTP visit schedule falls on a legal or clinic holiday. Designation of an OTP clinic holiday will be approved annually by the Office at least 30 days in advance of such holiday.

Late Dosing

Should an emergency arise, you may call the OTP and consideration may be given for your particular circumstances, however this does not guarantee that you will be able to present to OTP

for late dosing. Documentation of your circumstances may be necessary for approval of your request by the OTP Provider. Situations that will be considered for late dosing include car trouble, a medical emergency or appointment, and a law enforcement related delay (i.e. traffic ticket). Consideration for late dosing will not be given if documentation is not provided upon your presentation at CARS OTP.

Missed dose

Consistent dosing is a necessary part of your treatment; therefore, missing any dosing day is discouraged. If you miss three consecutively scheduled dosing visits, you will be assessed by medical personnel to determine whether a change in dose is needed. PLEASE BE ADVISED: If you miss your dose at CARS, you will be unable to get your dose of methadone at Cayuga Medical Center or any other area hospital.

Guest dosing

CARS OTP will offer guest dosing to clients from other OTPs with the appropriate information and referral. The sending clinic will hold the responsibility to determine a client's ability to travel and participate in guest dosing at CARS OTP. Emergency guest dosing will be addressed on an individual basis. Guest dosing referrals should be sent at least ten days prior to the guest's arrival at CARS. CARS will require that the guest complete an onsite EKG test. Referral for guest dosing must include the following information:

- Valid release of information
- Current list of medications
- Date and amount of last dose given
- Current physician's order for guest dosing which must include the first and last day the client will present to CARS OTP to guest dose.
- Description of client's current standing at sending clinic including attendance and any recent illicit drug use.
- Take-home schedule
- Any other pertinent information needed or requested by CARS OTP

Clients who present to CARS to guest dose MUST have a copy of their completed guest dosing referral from their sending OTP in a sealed envelope; this must be the same referral form that was previously faxed to CARS by the sending OTP. Client must also provide their identification and insurance information. If the guest does not have insurance, CARS will charge a sliding-scale fee with proper documentation.

Take-Home Doses

Each patient should be on an OTP visit schedule that is most appropriate to clinical need, conducive to treatment progress, and supportive of rehabilitation. A prescribing professional can reduce a patient's OTP visit schedule, when clinically indicated, only after assessing patient responsibility in handling approved medication and taking reasonable precautions to prevent possible misuse. A physician will review and confirm the appropriateness for take-home medication at least each time the comprehensive treatment plan is reviewed.

Patients will be granted take-home medication after a clinical review of the following:

- Adherence to a comprehensive treatment plan.
- Progress in maintaining a stable lifestyle, evidenced by:
    - absence of patterned drug use, including alcohol
    - regular OTP attendance
    - absence of criminal activity and/ or serious behavioral issues
    - stability of home environment and social relationships
    - employment or other productive activity
    - length of time in maintenance treatment
    - whether the rehabilitative benefit the patient would derive from decreasing the frequency of clinic attendance outweighs the potential risks of diversion
    - assurance that take-home medication shall be safely stored, including specific discussions on safety when there are children in the household

All the above criteria must be met for a client to receive take home medication.

Phases of Eligibility for Take-home Dosing

0-90 days in treatment (Phase 1)- Client is not eligible for take home medication except for the dose given to cover Sundays and federal holidays while the OTP is closed. This is the very early phase of treatment and clients will be expected to come to CARS OTP several times a week for groups and individual sessions in addition to daily for dosing.

3-9 months (Phase 2)- Client is eligible for up to 2 take home doses given at one visit. This is the early recovery phase of treatment and clients will be expected to come to CARS OTP for group and individual sessions per their treatment plan goals and agreed upon treatment recommendations.

9-12 months (Phase 3)- Client is eligible for up to 3 take home doses given at one visit.

1-2 years (Phase 4)- Client is eligible for up to 6 take home doses given at one visit.

2-3 years (Phase 5)- Client is eligible for no more than 30 take home doses given at one visit.

Phase Advancement

The minimum number of OTP scheduled visits must be met each week/month but may be increased based on individual needs. To be considered for phase advancement, your counselor will bring your case to the case review team meeting. There is no "maximum" amount of time in each phase, but rather clients must demonstrate that they are able to move forward in phase advancement.

Take-Home Combination Boxes

Each client will be REQUIRED to provide a take-home box that is combination locked. Combination lock boxes are sold at CARS for $15 per box. Please note: Take-home medication WILL NOT be supplied without a combination lock box.

Take-Home Bottles

Take-home medication doses will be given on a "one-for-one" basis, meaning for each take home bottle given, the same number needs to be returned to OTP to receive the next take home dose. Failure to return take-home bottles is an indication that a client may not be able to responsibly handle the medication outside of the treatment program. The failure to return take-home bottles may lead to termination of take-home privileges or a decrease in the number of doses you are able to take home.

Take home bottles are sealed with a label which must remain on the bottle(s) until the dose is taken at home. It is the client's responsibility to count and ensure they are given the correct number of take-home bottles prior to leaving the facility. CARS is not responsible to replace take-home bottles once the client has left the dosing window. Once the take-home bottle(s) is received, the client is unable to return to OTP for more take-home doses until the day the bottles are due back to CARS OTP.

Lost or Stolen Doses

Your take-home medication is a privilege, NOT A RIGHT, and should be considered a trust given to you in your treatment. The medication should be stored in a locked, child-proof box approved by the OTP before a take-home dose is scheduled. If your medication is lost or stolen, it should be reported to the police IMMEDIATELY. A police report must be completed and provided to CARS OTP. Lost, stolen, or spilled take-home medication may not be able to be replaced and may result in a loss of take-home privileges.

Revocation of Take-Home Privileges

Take-home medication is a privilege provided by the OTP prescriber and may be suspended at any time. Take-home privileges will be suspended if:

- You submit a positive urine drug screen or a urine drug screen negative for methadone.
- You refuse or are unable to produce a urine sample to submit for drug screening.
- Your group or individual session attendance is not in compliance with program rules.
- Your living situation becomes unsafe for the storage or administration of your Methadone.
- You become unemployed for more than 30 days after previously being employed.
- You become medically or psychiatrically unstable as determined by medical staff.
- You are in violation of the Medication Policy.

Medication Call Back

A provider can use the practice of recall to check for diversion of opioid medication. Recall happens when the OTP staff either randomly call back or have reasonable cause to suspect diversion and require a client to return to the OTP unexpectedly. OTP staff will call the client and the expectation is that the client will bring in all remaining take-home doses, with their labels intact, by 11:30AM the following day. Remaining doses must match the prescribed schedule and have the correct lot number. If the client is unable to produce their medication bottles or they are not intact this could lead to no longer being able to have take home doses.

Holding of Doses

If staff observes any condition or behavior of the client that may contraindicate a regularly scheduled dose, the medical provider will be contacted. The prescribing professional will then provide the medical direction regarding your dosing, and your dose may be held for your own safety.

Split Dosage

To receive a split dose there must be additional testing, approval from the medical provider, and approval from OASAS. All client who are approved for a split dose will be educated on the purpose of the split dose, safe storage of the take-home dose, and how to self-administer the second daily dose.

Pregnancy

Methadone and buprenorphine are Pregnancy Category C drugs. This means that these drugs have not been studied thoroughly in pregnant women and they may cause a risk to the fetus. Therefore, they need careful consideration by the prescriber and expectant mother. Pregnant women will receive priority admission to OTP and will be referred for pre and post-natal follow-up care for mother and child. If a pregnant client refuses the referred prenatal services, CARS OTP will use informed consent procedures to have the patient formally acknowledge, in writing, their refusal of these services.

Incarceration/Hospitalization

If you become incarcerated, you are at risk of being unable to receive your medication and may be subject to the detox protocol of the facility.

Medication Information

Methadone

Methadone is a medication used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates. Methadone has been used for decades to treat people who are addicted to heroin and narcotic pain medicines. When taken as prescribed, it is safe and effective. It allows people to recover from their addiction and to reclaim active and meaningful lives. For optimal results, patients should also participate in a comprehensive medication-assisted treatment (MAT) program that includes counseling and social support.

Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opiate drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. Methadone is offered in liquid and tablet form at CARS OTP and is taken once a day.

Methadone can be addictive, so it must be used exactly as prescribed. This is particularly important for patients who are permitted to take methadone at home and aren't required to take medication under supervision at an OTP. Methadone medication doses are specifically tailored for the individual patient (as doses are often adjusted and readjusted) and is never to be given to others. Patients should share their complete health history with their health providers to ensure the provider has all the information needed to prescribe a safe dose for you.

Other medications may interact with methadone and cause heart conditions so do not take any medications, **even over-the-counter medications** without checking with your provider first.

Methadone lasts in your body for days so even after the effects of methadone wear off, the medication's active ingredients remain in the body for much longer. This means that **taking more methadone than you were prescribed can cause an unintentional overdose.**

The following tips can help achieve the best treatment results:

- Never use more than the amount prescribed, and always take at the times prescribed. If a dose is missed, or if it feels like it's not working, **do *not* take an extra dose of methadone.**
- **Do not consume alcohol** while taking methadone.
- Be careful driving or operating machinery on methadone.
- **Call 911** if too much methadone is taken or if an overdose is suspected.
- Take steps to prevent children from accidentally taking methadone.
- Store methadone at room temperature and away from light

Serious Side Effects of Methadone

Side effects should be taken seriously, as some of them may indicate an emergency. Patients should stop taking methadone and contact a doctor or **emergency services** right away if they:

- **Have trouble breathing or breathing becomes shallow**
- **Feel light-headed or faint**
- **Experience hives or a rash; swelling of the face, lips, tongue, or throat**
- **Feel chest pain**
- **Experience a fast or pounding heartbeat**
- **Experience hallucinations or confusion**

Pregnant or Breastfeeding Women and Methadone (see Pregnancy)

Women who are pregnant or breastfeeding can safely take methadone. When withdrawal from an abused drug happens to a pregnant woman, it causes the uterus to contract and may bring on miscarriage or premature birth. Methadone's ability to prevent withdrawal symptoms helps pregnant women better manage their addiction while avoiding health risks to both mother and baby.

Undergoing methadone maintenance treatment while pregnant will not cause birth defects, but some babies may go through withdrawal after birth. This does not mean that the baby is addicted. Infant withdrawal usually begins a few days after birth but may begin two to four weeks after birth.

Mothers taking methadone can still breastfeed. Research has shown that the benefits of breastfeeding outweigh the effect of the small amount of methadone that enters the breast milk. A woman who is thinking of stopping methadone treatment due to breastfeeding or pregnancy concerns should speak with her doctor first.

Buprenorphine

Buprenorphine offers several benefits to those with opioid use disorder, and to others for whom methadone is not preferred or appropriate. CARS OTP offers the following buprenorphine products:

- Suboxone: buprenorphine and naloxone film
- Subutex: Buprenorphine-containing transmucosal products, for pregnant women with opioid use disorder

Refer to the product websites for a complete listing of drug interactions, warnings, and precautions.

Buprenorphine has unique pharmacological properties that help:

- Lower the potential for misuse
- Diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings
- Increase safety in cases of overdose

Buprenorphine is an opioid partial agonist. This means that, like opioids, it produces effects such as euphoria or respiratory depression. With buprenorphine, however, these effects are weaker than those of full agonist drugs, such as methadone.

Buprenorphine's opioid effects increase with each dose until at moderate doses they level off, even with further dose increases. This "ceiling effect" lowers the risk of misuse, dependency, and side effects. Also, because of buprenorphine's long-acting agent, many patients may not have to take it every day.

Side Effects of Buprenorphine

Buprenorphine's side effects are similar to those of other opioids and can include:

- Nausea, vomiting, and constipation
- Muscle aches and cramps
- Cravings
- Inability to sleep
- Distress and irritability
- Fever

Buprenorphine Safety

People should use the following precautions when taking buprenorphine:

- Do not take other medications without first consulting your doctor.
- Do not use illegal drugs, drink alcohol, or take sedatives, tranquilizers, or other drugs that slow breathing. Mixing large amounts of other medications with buprenorphine can lead to overdose or death.
- Do ensure that a physician monitors any liver-related health issues that you may have.

Pregnant or Breastfeeding Women and Buprenorphine

Limited information exists on the use of buprenorphine in women who are pregnant and have an opioid dependency. But the few case reports available have not demonstrated any significant problems resulting from use of buprenorphine during pregnancy. The FDA classifies buprenorphine products as Pregnancy Category C medications, indicating that the risk of adverse effects has not been ruled out. In the United States, methadone remains the current standard of care for the use of MAT with pregnant women who have opioid dependency.

Information on Relapse Prevention

If you are feeling the urge to use, try to wait out the craving by finding a sober activity to keep busy until the craving passes.

Focus on replacing your past behaviors or down time with new positive activities that do not involve exposure to substances.

Do not try to do this alone, contact your support system, or if you do not have a support system you can contact local self-help meetings to start connecting with people in the community.

Example of a basic Relapse Prevention Plan:

Support Network I can call

Name and Phone Number: 1. _____

2. _____

3._____

My Main Motivations for working on my recovery

1. _____
2. _____
3. _____

Local 12-Step/Self-Help Meetings I can attend:

_____

_____

My Counselor's contact information:

_____

NYS OASAS 24 Hour Help Hotline: (877)-8-HOPENY.

Warning signs of Relapse

- Denying vulnerability to relapse
- Creating justifications for substance use
- Not being active in recovery efforts (missing appointments, self-help meetings, etc.)
- Social problems
- Idealizing substance use (war stories)
- Neglecting emotional or physical health
- Boredom and Isolation
- High risk situations
- Unmanageable Stress

If you do relapse, don't give up. Get help. Contact your nearest support system i.e.: sponsor, family member, counselor, etc.

If emergency services are needed, call 911 and get to the nearest Emergency Room.

C.A.R.S. Cayuga Addiction Recovery Services

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 PLEDGE REGARDING MEDICAL INFORMATION

Centralus Health, Inc. ("Centralus Health") understands that information about you and your health is personal, and we are committed to protecting your protected health information. We create a medical record of the care and services that you receive at Centralus Health or one of its affiliates. We need this record to provide you with quality care and comply with certain legal requirements. This Notice of Privacy Practices ("Notice") apply to all records relating to your care generated by Centralus Health or one of its affiliates, whether made by Centralus Health personnel or your personal doctor. Your personal doctor, outside of Centralus Health, may have different policies or notices regarding that doctor's use and disclosure of your protected health information created or maintained in that doctor's office or clinic.

This Notice tells you about the ways in which we may use and disclose your health information. It also describes your rights with respect to your health information. We are required by law to: (i) maintain the privacy of your health information; (ii) provide you with this Notice describing our legal duties and privacy practices with respect to your health information; and (iii) follow the terms of the Notice that is currently in effect. State law may provide additional restrictions on the use and disclosure of certain information such as HIV/AIDS-related information, substance use disorder information, and mental health information. Centralus Health will follow any such requirements.
We reserve the right to change the terms of this Notice at any time and to make the new notice effective for health information we already have about you as well as any health information we receive about you in the future. A copy of the current notice will be posted on our website, www.centralushealth.org, and made available upon request.

Additionally, for the privacy of our patients, residents and staff, we ask that you do not take photos or video of other patients, residents, or staff without their prior permission.

WHO FOLLOWS THIS NOTICE

The terms of this Notice apply to Centralus Health's affiliated covered entities, including, but not limited to Centralus Health, Inc., Arnot Health, Inc., Arnot Ogden Medical Center, The Ira Davenport Memorial Hospital, Inc., St. Joseph's Hospital, Arnot Medical Services, PLLC, Cayuga Health System, Inc., Cayuga Medical Center at Ithaca, Inc., Schuyler Hospital, Inc., Cayuga Health Transport, LLC d/b/a Centralus Health Ambulance, ***Ithaca Alpha House Center, Inc. d/b/a Cayuga Addiction Recovery Services***, Visiting Nurse Service of Ithaca and Tompkins County, Inc., Community Health and Home Care, Inc., Cayuga Medical Associates, P.C., CMA Medical Practice, PLLC, Cayuga Medicine Services, PLLC, Cayuga Physician Practice, PLLC, Cayuga Health Medical Services, PLLC, Ithaca Medical Services, PLLC, and Cayuga Medical Equipment, LLC.

Centralus Health and its affiliates' employees, medical staff, trainees, students, volunteers, and agents are required to follow the terms of this Notice. This Notice apply to all of the previously mentioned persons and entities at any site or location owned or operated by Centralus Health. In addition, these persons and entities may share protected health information with each other for treatment, payment or health care operation purposes as described in this Notice and as permitted by law.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION THAT DO NOT REQUIRE AN AUTHORIZATION

Centralus Health may use or disclose your health information without your authorization as described in this section. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use or disclose protected health information will fall within one of these categories.

Treatment: We may use and disclose your protected health information to provide you with medical treatment or services. For example, we may share your health information with health care providers within and outside of Centralus Health who are involved in your care to coordinate your care or plan a course of treatment for you. This may include people or entities involved in your medical care after you leave Centralus Health, such as family members or others we use to provide services that are part of your care.

Payment: We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive. For example, we may disclose information to your health insurance company about surgery you received at Centralus Health so your health insurance company will pay us or reimburse you for the surgery. We may also tell your health insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

Health Care Operations: We may use and disclose your health information for our business operations. These uses and disclosures are necessary to operate Centralus Health and help ensure that our patients receive high quality care and that our health care providers receive superior education. For example, we may use and disclose your health information to conduct an evaluation of the treatment and services provided or to review staff performance.

Health Information Exchanges: We participate in initiatives to help facilitate the electronic sharing of our patients' health information, including, but not limited to, Health Information Exchanges (HIEs).

HIEs involve coordinated information sharing among HIE participants for purposes of treatment, payment, and health care operations. This means that with your consent, or in some circumstances, without your consent such as in the case of emergencies, we may share your health information with non-Centralus Health entities involved in your care (such as hospitals, doctors offices, pharmacies, or insurance companies) who participate in the HIE, or we may receive information they create or maintain about you so each of us can provide better treatment and coordination of your health care services.

Hospital Directories: If you are hospitalized, we may include certain limited information about you in our hospital directory, including your name, room number, general condition, and, if you wish, your religious affiliation. Unless you choose to have your information excluded from this directory, the information, excluding your religious affiliation, may be disclosed to anyone who requests it by asking for you by name.

This information, including your religious affiliation, may also be provided to members of the clergy, even if they do not ask for you by name. If you wish to have your information excluded from this directory, please let a member of your care team know.

Communicating with You: We may use or disclose your health information to communicate with you about a number of important topics, such as your upcoming appointments, care, or treatment alternatives or other health-related services that may be of interest to you.
We may contact you at the email address, phone number (including via text message), or home address that you provide to us. If your contact information changes, it is important you let us know.
We recommend that you use secure electronic communications, such as MyChart, our patient portal, when you contact us. If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or phone number from which you sent your communication. Before using or agreeing to the use of any unsecure electronic communication to communicate with us, note that there are certain risks associated with such use, including interception of the message by others, misdirected messages, or storage of your information on devices that are not secure. By choosing to communicate with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Email and text communications are not a substitute for professional medical advice, diagnosis, or treatment and should never be used in a medical emergency.

Fundraising: We may contact you at times to donate to a Centralus Health fundraising effort. You have the right to opt-out of these fundraising communications. Any fundraising communication sent to you will include information on how you can opt-out of receiving similar communications in the future.

Persons Involved in Your Care: We may disclose your health information to a family member, friend, or any other person identified by you who is involved in your care or payment for care, unless you object. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may use our professional judgment to determine whether a disclosure is in your best interests. If your health information is disclosed to a family member, friend, or other individual involved in your care, we will disclose only information believed to be directly relevant to the person's involvement with your care or payment for your care. We also may disclose a limited amount of your health information to an entity authorized to assist in disaster relief efforts for the purpose of coordinating notification of your general condition or location to someone responsible for your care.

Research: We may use and disclose your health information as permitted by law for research. All research projects that Centralus Health conducts or participates in must be approved through a special review process.

Business Associates: We engage persons or entities outside of Centralus Health to perform certain services on our behalf, such as billing and legal services. These outside persons and organizations are referred to as "business associates". At times, we may need to disclose your health information to our business associates to enable them to perform the services on our behalf. In such instances, we require these business associates and their subcontractors to appropriately safeguard your health information.

Additional Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your health information without your authorization. Subject to conditions specified by law, we may disclose your health information:

- for any purpose required by law;
- if required by a court or administrative order, subpoena, discovery request, or other legal process;
- to certain government agencies if we suspect child/elder adult abuse or neglect, or if we believe you are a victim of abuse, neglect, or domestic violence;
- for certain law enforcement purposes, including to identify or locate a suspect, fugitive, material witness, missing person or victim of a crime or to report a crime on our premises;
- for specialized government functions, such as protection of public officials, reporting to various branches of the armed services, or, if you are an inmate, to a correctional institute with lawful custody;
- for national security, intelligence, or protective services activities;
- for purposes related to your workers' compensation benefits;
- for public health activities, such as required reporting of disease, injury, birth, and death, for required public health investigations, and to report adverse events or enable product recalls;
- to a government oversight agency conducting audits, investigations, inspections, and related oversight functions;
- to your employer when we have provided screenings and health care to you at their request for occupational health and safety;
- in emergencies, such as to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of another person or the public;
- to medical examiners, funeral directors, or coroners as necessary for them to carry out their lawful duties; and
- if necessary, to arrange for organ or tissue donation or transplant

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION BASED ON A SIGNED AUTHORIZATION

Except as generally outlined above, we will not use or disclose your health information for any other purpose unless you have signed a form authorizing the use or disclosure. If you provide us with written authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time; however, your revocation will not apply to uses and disclosures made in reliance on your authorization prior to your revocation.
Some examples of when a signed authorization form is required include:

- most uses and disclosures of psychotherapy notes;
- uses and disclosures for certain marketing purposes;
- disclosures that constitute a sale of your health information;
- uses and disclosures for certain research protocols; and
- As required by applicable privacy laws.

SPECIAL CONSIDERATIONS

HIV/AIDS, genetic testing, substance use disorder, mental and behavioral health, and other sensitive treatment records, as well as records related to treatment you may have received as an emancipated minor, may have additional legal protections under federal and state laws. Generally, we may not disclose

such information unless you consent in writing, the disclosure is allowed by a court order, or in other limited, regulated circumstances.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your PHI: You have the right to request a restriction on certain uses and disclosures of your health information for treatment, payment, or health care operations. We are not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. You may request a restriction by submitting the appropriate form, which can be obtained by contacting Centralus Health's Privacy Office.

Restrictions on Disclosures to Health Plans: You have the right to request a restriction on certain disclosures of your health information to your health plan. We are required to honor such requests only when you or someone on your behalf, other than your health plan, pays for the health care items(s) or services(s) in full. Such requests must be made in writing and identify the services to which the restrictions will apply. You may request a restriction by submitting the appropriate form, which can be obtained by contacting Centralus Health's Privacy Office.

Access to Your Health Information: With certain exceptions, you have the right to inspect and obtain an electronic or paper copy of health information that we maintain about you. You may readily access much of your health information without charge via MyChart, our patient portal. For additional information regarding MyChart, including sign-up information, please visit https://cayugahealth.org/about/mychart. You may also access your health information by submitting a request to our Health Information Management department or your Centralus Health affiliated physician's office. We may charge you for a copy of your medical records in accordance with set fees under federal and state law.

Confidential Communications: You have the right to request that we communicate with you through alternative means or at alternative locations, and we will accommodate reasonable requests. Such requests must be made in writing. The appropriate form can be obtained by contacting Centralus Health's Privacy Office.

Amendments to Your Health Information: You have the right to request an amendment, or change, to certain health information that we maintain about you that you think may be incorrect or incomplete. All requests for changes must be made in writing using our designated form, signed by you or your legal representative, and state the reason(s) for the request. Note that if we accept your request, we may not delete any information already documented in your medical record. We will, however, add the supplemental or corrective information via an addendum. If we deny your request, we will tell you why in writing and explain your rights. Our amendment request form can be obtained by contacting the facility where you received your care or Centralus Health's Privacy Office.

Accounting of Disclosures of Your PHI: You have the right to receive an accounting of certain disclosures made by us of your health information. Disclosures made for purposes of treatment, payment, or healthcare operations, or for certain other limited purposes, will not be included in the accounting. Requests must be made in writing and signed by you or your legal representative. We will provide the first accounting you request in any 12-month period for free. We will charge you a reasonable, cost-based fee

for each subsequent accounting you request within a 12-month period. You may request an accounting by submitting the appropriate form, which can be obtained by contacting Centralus Health's Privacy Office.

Breach Notification: We are required to notify you in writing of any breach of your unsecured health information without unreasonable delay, but in any event, no later than 60 days after we discover the breach.

Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice, even if you agreed to receive an electronic copy. A paper copy of our current notice is available at our registration areas. You can access an electronic version of our current notice on our website, www.centralushealth.org.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Centralus Health's Privacy Office (contact information below). You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. A complaint will not in any way affect the quality of care we provide you.

CONTACT

If you have questions about this Notice, or requests regarding privacy, please contact:

Centralus Health's Privacy Office
Address: 101 Dates Drive, Ithaca, NY 14850
Phone: 607- 274-4494
Email: clouey@cayugamed.org

C.A.R.S. Cayuga Addiction Recovery Services

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

By signing this acknowledgement, I attest that I have received, read, and understand the Notice of Privacy Practices, which provides a detailed description of how my health information may be used and disclosed. I have been provided a copy of this Notice and have had the opportunity to ask questions regarding its contents. I understand that Cayuga Addiction Recovery Services (CARS), as part of its affiliation with Centralus Health's Covered Entities, may update its Notice of Privacy Practices periodically. I may request the most current version at any time by contacting the organization at the address listed in the *Contact* section above.

I acknowledge that I have received and reviewed the Notice of Privacy Practices and understand my rights regarding the use and protection of my health information.

_____	_____	_____
Patient Name (*Print*)	**Patient Signature**	**Date of Birth**

_____	_____
Authorized Legal Representative Name (*Print*)	**Authorized Legal Representative Signature**

INSTRUCTIONS for Office Staff (Internal Use Only)

- *One (1) copy of the Notice of Privacy Practices is provided to the patient at the time of review.*
- *One (1) copy of the Notice of Privacy Practices, along with the signed Acknowledgement Page, is retained in the patient's record.*
  - *This should be uploaded as a single document into the case record, including all pages (1–7).*
- *This Notice and Acknowledgement do not serve as a Release of Information (ROI).*
- *If disclosure of information is required to facilitate treatment, billing, or healthcare operations, a separate Consent for Release of Information (ROI) must be completed.*

C.A.R.S.
CAYUGA ADDICTION RECOVERY SERVICES
A Member of Centralus Health

Patient Rights and Responsibilities

Each patient has the following rights and cannot be denied, suspended or discharged from services for exercising your rights.

(1) to receive services responsive to individual needs in accordance with an individualized treatment/recovery plan, which the patient helps develop and periodically update;
(2) to receive services from provider staff who are competent, respectful of patient dignity and personal integrity, and in sufficient numbers to deliver needed services consistent with the requirements of the provider's operating certificate;
(3) to receive services in a therapeutic environment that is safe, sanitary, and free from the presence of addictive substances;
(4) to know the name, position, and function of any person providing treatment to the patient, and to communicate with the provider director, medical director, board of directors, other responsible staff or the Commissioner;
(5) to receive information concerning treatment, such as diagnosis, condition or prognosis in understandable terms, and to receive services requiring a medical order only after such order is executed by a medical provider working within their scope of practice;
(6) to receive information about provider services available on site or through referral, and how to access such services;
(7) to receive a prompt and reasonable response to requests for provider services, or a stated future time to receive such services in accordance with an individual treatment/recovery plan;
(8) to be informed of and to understand the standards that apply to their conduct, to receive timely warnings for conduct that could lead to discharge and to receive incremental interventions that are strength based, person centered and trauma-informed for conduct contrary to program rules;
(9) to receive in writing the reasons for a recommendation of discharge and to be informed of the process to appeal such discharge recommendation;
(10) to voice a grievance, file a complaint, or recommend a change in procedure or service to provider staff and/or the Office, free from intimidation, reprisal or threat;
(11) to examine, obtain a receipt, and receive an explanation of provider bills, charges, and payments, regardless of payment source;
(12) to receive a copy of the patient's records for a reasonable fee;
(13) to be free from physical, verbal or psychological abuse;
(14) to be treated by provider staff who are not under the influence of substances that would impair their ability to perform the duties stated in their job description;
(15) to be free from any staff or patient coercion, undue influence, intimate relationships and personal financial transactions;
(16) to be free from performing labor or personal services solely for provider or staff benefit, that are not consistent with treatment goals, and to receive compensation for any labor or employment services in accordance with applicable state and federal law; and
(17) the following rights apply to patients who reside in an inpatient/residential setting:

(i) to practice religion in a reasonable manner not inconsistent with treatment/recovery plans or goals and/or have access to spiritual counseling if available;

(ii) to communicate with outside persons in accordance with the individualized treatment/recovery plan;

(iii) to communicate freely with the Office, public officials, clergy, attorneys and other persons identified by the patient;

(iv) to receive visitors at reasonable times in relative privacy in accordance with the individualized treatment/recovery plan;

(v) to be free from restraint or seclusion;

(vi) to have a reasonable degree of privacy in living quarters and a reasonable amount of safe personal

storage space;

(vii) to retain ownership of personal belongings, to the extent such belongings are not contrary to program rules; and

(viii) to have a balanced and nutritious diet.

(18) participants referred to a faith-based provider have the right to be given a referral to a non-faith based provider.

(19) Patients have the right to placement in gender segregated settings based on their gender identity or expression.

(20) Patients have the right to culturally appropriate and affirming care and to be free from harassment and/or discrimination in accordance with the factors outlined in paragraph (21) of this subdivision.

(21) Prohibition against discrimination in admission. No individual that meets level of care criteria for admission shall be denied admission to any program based solely on the following factors, including but not limited to:

(i) prior treatment history;

(ii) referral source;

(iii) pregnancy;

(iv) history of contact with the criminal justice system;

(v) HIV status;

(vi) physical or mental disability;

(vii) lack of cooperation by significant others in the treatment process;

(viii) toxicology test results;

(ix) use of any substance, including but not limited to, benzodiazepines; or

(x) use of medications for substance use disorder prescribed and monitored by an appropriate practitioner;

(xi) actual or perceived gender or gender identity;

(xii) national origin;

(xiii) race or ethnicity;

(xiv) actual or perceived sexual orientation;

(xv) marital status;

(xvi) military status;

(xvii) familial status; or

(xviii) religion; or

(xix) age.

(22) Patients have the following rights with regard to access to medication for addiction treatment:

(1) Medication for Addiction Treatment (MAT) for Substance Use Disorder.

(i) Patients have the right to be offered or maintained on all forms of approved medication for substance use disorder treatment when admitted or seeking admission to any Office certified program, in accordance with guidance issued by the Office.

(ii) Patients have the right to be educated about all forms of FDA approved medications for the treatment of substance use disorders, including the benefits, risks and alternatives.

(23) Overdose Prevention Education. (i) Patients have the right to receive overdose prevention education and naloxone education and training, and a naloxone kit or prescription, in accordance with guidance issued by the Office.

Patient Responsibilities

Participation in treatment for an addiction disorder presumes a patient's continuing desire to acquire healthy habits and requires each patient to act responsibly and cooperatively with provider staff, in accordance with an individual treatment/recovery plan and reasonable provider procedures. Therefore, each patient is expected to:

(1) work toward the goal of recovery, as defined by the patient;

(2) treat staff and other patients with courtesy and respect;

(3) respect other patients' right to confidentiality;

(4) participate in developing and following a treatment/recovery plan;

(5) become involved in productive activities according to ability;

(6) pay for services on a timely basis according to financial means;

(7) participate in individual counseling and/or group and/or family counseling sessions as appropriate;
(8) inform medical staff if receiving other medical or psychiatric services;
(9) address all personal issues adversely affecting treatment; and
(10) act responsibly and observe all provider rules, regulations and policies.
(b) Addressing patient non-adherence.
(1) Provider policies and procedures to address patient nonadherence shall be strength-based, person-centered, trauma-informed and designed to support a patient's positive response to treatment. Such policies and procedures must specify standards and expectations for patient conduct, and any consequences of non-adherence, including conduct which may result in treatment termination.
(2) Providers shall address patient non- adherence with timely and appropriate incremental interventions that are strength-based, person centered, trauma-informed, and designed to assist patients in responding positively to treatment. Such incremental interventions shall be incorporated in the patient's treatment/recovery plan, be time-limited, and be documented in the patient's record.
(3) No treatment intervention or action can include delay or denial of any clinical, medical, or other required services vital to the health or recovery of the patient.
(4) Providers shall first warn patients of any conduct that could result in a recommendation of discharge with continued non- adherence, and must document such warning(s) in the patient's record.
(5) Patients have the ability to consent or refuse treatment recommendations from the program. Providers may not discharge a patient solely for their refusal to participate in a recommended service.

Treatment at CARS is voluntary, clients have the ability to discharge themselves at any time. Although external commitments or legally imposed directives may create situations where treatment does not seem voluntary.

Additional Client Rights

- You have the right to receive information that will help you make decisions about your treatment, including your own records. You may request the records electronically or hard copy within 30 days of the approved request.
- You have the right to state your preferences and make decisions about your substance use treatment, including agreeing to or refusing specific kinds of services.
- You have the right to be free from abuse or neglect. Our Code of Conduct and Ethics prohibits physical abuse, sexual abuse, financial abuse, harassment and physical punishment. This Code also prohibits psychological abuse, including humiliating, threatening and exploiting actions.
- Withdrawal from service delivery at any time
- Ability to sign and withdraw (revoke) any consents to releases of information – these requests must be in writing
- Concurrent services during engagement in treatment
- Access to the service delivery team
- Involvement in research projects if possible
- You have a right to request access or referrals to legal entities for appropriate representation, self-help support services and/or advocacy support services.
- You have a right to request access or referrals to legal entities for appropriate representation, self-help support services and/or advocacy support services.
- You have the right to refuse to participate in or be interviewed for research purposes. If you choose to participate, there will be strict adherence to research guidelines and ethics.
- You have the right to request an investigation and/or resolution of any alleged infringement of your rights.
- You have the right to be treated in a way that recognizes and responds to your cultural identity and/or disability and/or sexual orientation and/or sex.
- You have the right to examine and receive an explanation of your bill regardless of the source of payment.

- You have the right to receive services in a physical environment that is safe, sanitary, reflective of human dignity, conducive to effective treatment, and which appropriately safeguards the privacy and confidentiality of patient staff interactions.
- You have a right to an individually designed plan of services based on your individual needs. You have the right to participate in the development of that plan and to include goals you have agreed to work toward.
- You have the right to be free from any staff or patient coercion, undue influence, intimate relationships and personal financial transactions.
- You have the right to receive a prompt and reasonable response to requests for provider services, or a stated future time to receive such services in accordance with an individual treatment/recovery plan.
- You have the right to considerate and respectful care.

I have received and understand the Cayuga Addiction Recovery Services Notice of Privacy Practices and Client Rights.

I understand that treatment is voluntary, and I have the right to discharge myself at any time.

_____ _____

Client Name Date

_____

Client Signature

The following topics and information have been reviewed with me by CARS staff, I understand them, and have had the opportunity to ask questions.

Handbook Sections
What CARS Opioid Treatment Program is
Medication Policy
Consents
Statement of Client Rights
Notice of Confidentiality requirements
HIV-related information
Program Rules and Regulations
Statement of voluntary participation and consent to treatment
Toxicology/ Policy for collection of samples
CARS OTP Tobacco Free client agreement
Attendance Policy
Text message disclosure
Gambling Free client agreement
Program Financial Policy
Consideration of induction process
Medication Administration scheduling (late dosing, missed dosing, split dosing, and guest dosing)
Take Home doses, phase advancement, lost/stolen doses, and take-home bottles, holding doses, medication recall, incarceration/hospitalization
Methadone
Buprenorphine
Information on Relapse Prevention
Consent information and expiration

By signing below, I attest that I have received a copy of the handbook containing all the contents listed above.

Client Name: _____

_____ _____ _____ _____

Client Signature Date Staff Witness Signature Date

CONSENT TO NEW YORK STATE CENTRAL REGISTRY
42 CFR Part 2 and HIPAA

I have been informed and understand that my Substance Use Disorder (SUD) records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Therefore I, _____, *[name]* authorize

Cayuga Addiction Recovery Services, 334 W. State St., Ithaca, NY 14850 *[name and address of OTP]* to disclose my:

- First and Last Name
- Gender
- Admission Date
- SUD Medication Dosage
- Alias
- Birth Date
- Discharge Date
- SUD Medication Issued Through Date
- Photographic Image
- Mother's First Name
- SUD Medication Type/Form
- Last Four Digits of Social Security Number

to the New York State Central Registry operated by LightHouse Software Systems located at 17352 Derian Avenue, Irvine, CA.

The New York State Central Registry will contain presently prescribed/ordered medication(s) used for my Medication Assisted Treatment including dosage. This information will reside in the New York State Central Registry system for five years or while I remain a patient at this clinic, whichever period of time is longer and will be available to staff where I may present for admission or courtesy dosing. My name will be encrypted in the New York State Central Registry System database with technology that will meet HIPAA compliance requirements.

I have been informed and understand that this is to prevent an interruption in my treatment and/or care and prevent multiple simultaneous Medication Assisted Treatment program enrollments. I understand that this information will be viewed by staff at any New York State certified OTP when I present and request enrollment.

I understand that I will be denied services if I refuse to consent to a disclosure for purposes of determining multiple simultaneous Medication Assisted Treatment program enrollments.

Additionally, I have been informed and understand that I may revoke this consent at any time, fully understanding that doing so will terminate my current treatment episode. Consent may be terminated in writing at any time except to the extend that action has been taken in reliance upon it. Termination of this consent will not prohibit or be prejudice other/future admissions. I have been provided a copy of this form.

*Signature of Patient*_____ *Dated*: _____

*Signature of Parent/Guardian*_____ *Dated:* _____

Consent to Receive Communications from The Central Registry

The Central Registry is operated by Lighthouse Software Systems, LLC., located at 17352 Derian Ave., Irvine, CA 92614. Lighthouse will not send any promotional, marketing or solicitation messages to you. Lighthouse will not sell, share or use your contact information for any purpose other than the messages sent by your treatment provider. By providing your mobile number, you agree that Lighthouse Software Systems, LLC may send you periodic SMS or MMS messages containing but not limited to important clinic information generated by your OTP/NTP.

I understand that by voluntarily providing my mobile number and/or email address, I opt-in and agree to receive communications from The Central Registry on behalf of my treatment provider, Cayuga Addiction Recovery Services.

(*Please print the name of your treatment facility clearly)*

I understand and hereby authorize my treatment provider to send messages from The Central Registry to me for a variety of purposes, including but not limited to:

- Service disruption notifications
- Emergency closures
- Appointment reminders
- Counseling / counselor reminders

I understand that the following data may be collected:

- My mobile phone number
- My mobile service provider's name
- My email address
- Date and time of messages sent to me
- Content of messages sent to me

My Current Cell Phone Number:_____

And/Or My Current Email Address:_____

Standard Messaging Terms and Conditions

- Message frequency will vary
- You may unsubscribe at any time by texting the word STOP to (239)341-7182. You will receive a subsequent message confirming your opt-out request.
- For help, send the word HELP to (239)341-7182 or email info@thecentralregistry.com.
- Message and data rates may apply.
- United States Participating Carriers Include AT&T, T-Mobile®, Verizon Wireless, Sprint, Boost, U.S. Cellular®, MetroPCS®, InterOp, Cellcom, C Spire Wireless, Cricket, Virgin Mobile and others.
- U.S. based carriers are not liable for delayed or undelivered messages.
- You agree to notify us of any changes to your mobile number and update your account with us to reflect this change.
- Data obtained from you in connection with this SMS service may include your cell phone number, your carrier's name, and the date, time and content of your messages, as well as other information that you provide. We may use this information to contact you and to provide the services you request from us.
- By subscribing or otherwise using the service, you acknowledge and agree that we will have the right to change and/or terminate the service at any time, with or without cause and/or advance notice.

Name: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

OPIOID TREATMENT PROGRAM
CONSENT TO PARTICIPATE

CAYUGA ADDICTION RECOVERY SERVICES
334 West State Street
Ithaca, NY 14850
Phone: (607) 273-5500
Fax: (607) 273-1277

Patient Name: Date:

I hereby authorize and give voluntary consent to CARS OTP and its medical personnel to dispense and administer opioid pharmacotherapy (including methadone or buprenorphine) as part of the treatment of my addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed opioid drug at the schedule determined by CARS OTP provider, or his/her designee, in accordance with federal and state regulations.

It has been explained that, like all other prescription medications, opioid treatment medications can be harmful if not taken as prescribed. I further understand that opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical provider who may treatment for any medical problem that I am enrolled in an opioid treatment program, so that the provider is aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my opioid pharmacotherapy or my chances of successfully recovery from addiction. It is also important to inform my providers of my involvement in an opiate treatment program so I can avoid dangerous medication interactions that may harm me or even be fatal.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand I will be offered medically supervised withdrawal.

For Female patients or childbearing age: there is no evidence that methadone pharmacotherapy is harmful during pregnancy. If I am or become pregnant, I understand that it is my responsibility to tell my medical provider right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in opioid pharmacotherapy.

_____	_____	_____
Client Name (Print)	**Client Signature**	**Date**

Witness Statement: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provide to the patient and/or the patient's authorized representative (Signature below).

_____	_____	_____
Witness Name (Print)	**Witness Signature**	**Date**

THE MISSION STATEMENT OF CAYUGA ADDICTION RECOVERY SERVICES
A professional community resource providing caring and effective recovery services dedicated to improving the quality of life by promoting individual dignity and respect for all.

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Revoked On:_____ Staff Initials:_____

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

Patient's Last Name	First	M.I.
Case Number		
Facility: Cayuga Addiction Recovery Services	Unit: Ithaca OP 334 W. State St., Ithaca, NY 14850	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigating or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for the Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6. and/or

60 days after discharge

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)