



EMERGENCY CONTACT

EMERGENCY CONTACT INFORMATION

In the event of an emergency, I authorize Canvas Health to contact the following individuals

Name: _____

Phone Number: _____

Relationship to Client: _____

Name: _____

Phone Number: _____

Relationship to Client: _____

Client Name: _____ Date of Birth: _____

Client/Guardian Signature (if client under 18)

Date

PRIVACY PRACTICES (HIPAA)

Your Information. Your Rights. Our Responsibilities.

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.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say no to your request, but we'll tell you why in writing within 60 days. Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say yes to all reasonable requests.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say no if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say yes unless a law requires us to share that information. Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation Include your information in a hospital directory

Contact you for fundraising efforts

- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes in the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways

Treat You

- We can use your health information and share it with other professionals who are treating you.
Run our organization
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
 - For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
- Help with public health and safety issues
- We can share health information about you for certain situations such as:
 - Preventing disease, helping with product recalls, Reporting adverse reactions to medications,
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
- Do research
- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers compensation, law enforcement, and other government requests
- We can use or share health information about you: For workers compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We do not maintain psychotherapy notes at this practice. Minnesota, does not restrict client's rights to psychotherapy notes [Minn. Stat. 144.292, subd. 2]
- In Minnesota, we need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent. [Minn. Stat. 13.386, 254A.09]

Examples of legal disclosures include but are not limited to:

- Suicide or Homicide: if you are assessed to be a danger to yourself or others; cannot guarantee your physical safety against the intention of suicide or fatal harm to others; and/or have immediate suicidal plans, this information is not considered to be confidential. Actions may be taken to ensure your safety.
- Child abuse/neglect: Minnesota State Law requires your provider to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of child abuse or neglect. This law also applies to past incidents of abuse or neglect.
- Elder abuse/neglect: Minnesota State Law requires your provider to report to the appropriate authorities any suspicion or evidence of elder abuse/neglect.
- Vulnerable adult abuse/neglect: Minnesota State Law requires your provider to report to the appropriate authorities any suspicion or evidence of abuse or neglect.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Notice is effective: 7-1-2020

This Notice of Privacy Practices applies to the following organizations:

Canvas Health, Canvas Health Inc., HSI-New Generations LLC (discontinued)

Since Canvas Health Inc. is a Hybrid Entity the following programs are not included:

1. Substance Use Early Interventions
2. Abuse Response Services
3. Housing where we are the landlord
4. Mosaic Homes
5. Share Apartments
6. Home Free Apartments
7. Suicide Prevention Program
8. Emergency Social Services Anoka County
9. Emergency Social Services Scott County
10. Vocational
11. Forensic Services

HIPAA Privacy Officer: Jay Theisen, MSW, LICSW HIPAA Privacy Officer 7066 Stillwater Boulevard North, Oakdale, MN 55128 651.251.5029 Direct | 651.251.5111 Fax | hipaa@canvashealth.org | www.canvashealth.org

Client Name: _____ Date of Birth: _____

Client/Guardian Signature (if client under 18)

Date



INSURANCE/FINANCIAL

INSURANCE ASSIGNMENT and RELEASE

I, the undersigned, certify that I (or my dependent) have payer coverage and assign directly to Canvas Health all payer benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by payer. I hereby authorize Canvas Health to release all information necessary to secure the payment of benefits and to mail patient statements.

I authorize the use of this signature on all payer submissions.: YES or NO

The person signing this form is the individual who is financially responsible for all client services. It should be their address and phone that is entered here.

Address: _____

Phone Number: _____

Client Name: _____ Date of Birth: _____

Client/Guardian Signature (if client under 18)

Date



TELEHEALTH AGREE

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care.

Telehealth services also include remote monitoring, telepharmacy, prescription refills, appointment scheduling, regional health information sharing, and non-clinical services, such as education programs, administration, and public health.

Canvas Health providers may include psychiatry, mental health professionals/practitioners, Licensed Alcohol and Drug Counselors, and/or subspecialists.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) patient medical records; (2) medical images; (3) live two-way audio and video; (4) interactive audio; (5) store and forward electronic communications; and (6) output data from medical devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Improved access to medical care by enabling you to remain in your local healthcare site (e.g., home) while the provider consults and obtains test results at distant/other sites.

More efficient evaluation and management. Obtaining expertise of a specialist.

Possible Risks:

Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.

In rare events, the provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your provider.

In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

By signing below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Medical Group's services via telehealth technologies. I also understand it is up to the Medical Group provider to determine whether or not my needs are appropriate for a telehealth encounter.
2. I have been given an opportunity to select a consulting provider from the Medical Group prior to the consult, including a review of the consulting provider's credentials.
3. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Canvas Health will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
4. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Canvas Health.
5. I agree to hold harmless Canvas Health for delays in evaluation or for information lost due to such technical failures. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate access to the service at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Canvas Health health service specialists are not able to connect me directly to any local emergency services.
6. I understand the alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of Canvas Health consulting healthcare provider (e.g. labs or bloodwork).
7. I understand that sessions may also be monitored for training, audit, support, or other reasons associated with my care.



canvas HEALTH

7066 Stillwater Boulevard North, Oakdale, MN 55128-3937

8. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured
9. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the Canvas Health provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth session/examination; and/or (3) terminate the consultation at any time
10. If applicable, I understand that any Drug Enforcement Agency controlled substances are prescribed at the sole discretion of the provider in compliance with federal and state regulations. There is no guarantee that I will be given a prescription at all. Medical Group may require an in-person visit from time to time to continue to prescribe medications
11. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.
12. I understand that in the event of any problem with the website or related services, I agree that my sole remedy is to cease using the website or terminate access to the service. Under no circumstances will Medical Group or any Medical Group subsidiary or affiliate be liable in any way for the use of the telehealth services, including but not limited to, any errors or omissions in content or infringement by any content on the website of any intellectual property rights or other rights of third parties, or for any losses or damages of any kind arising directly or indirectly out of the use of, inability to use, or the results of use of the website, and any website linked to the website, or the materials or information contained on any or all such websites. I agree that I will not hold Medical Group, its subsidiaries or affiliates liable for any punitive, exemplary, consequential, incidental, indirect or special damages (including, without limitation, any personal injury, lost profits, business interruption, loss of programs or other data on my computer or otherwise) arising from or in connection with your use of the website whether under a theory of breach of contract, negligence, strict liability, malpractice or otherwise, even if we or they have been advised of the possibility of such damages.
13. I understand that Canvas Health makes no representation that materials on this website are appropriate or available for use in any other location. I understand that if I access these services from a location outside of the United States, that I do so at my own risk and initiative and that I am ultimately responsible for compliance with any laws or regulations associated with my use.
14. All Canvas Health policies and practices, risks and benefits noted in other places still apply to services provided via telehealth. This includes but is not limited to payment. Being that services are provided to you outside of our facilities, you are responsible for privacy in the environment for which you are in during a telehealth visit. You can expect that your service is provided in a private location by your provider

I have read this document carefully, and understand the risks and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telehealth consultation under the terms described herein.

Client Name: _____ Date of Birth: _____

Client/Guardian Signature (if client under 18)

Date