COMHAR INC.

Supporting Growth and Purpose Through Community

Participant's Name (Last, First, M.I):	Date of Birth:
	—

CONSENT AND AUTHORIZATION FOR TREATMENT

☐ **OUTPATIENT MENTAL HEALTH**	☐ **PSYCHIATRICT REHABILITATION**
☐ **CASE MANAGEMENT**	☐ **MENTAL HEALTH RESIDENTIAL SERVICES**
☐ **ICF RESIDENTIAL**	☐ **IBHS**
☐ **MDE**	☐ **ID**

I have received a full explanation of the treatment process, possible treatment interventions and options, and the potential for the prescription of medication(s) when appropriate for the level of care stated above. The expected benefits and any risks of treatment as well as the possible risks of not receiving treatment have been fully explained to me. I am aware that I have the right, to the extent permitted by law, to withdraw from treatment at my request and if I choose to do so, I will give my treatment team the opportunity to discuss further options with me.

For children under 14 years of age I agree that treatment for my child may consist of screening, psychiatric assessment, individual, group, and/or family therapy, and/or the prescription of medication. I agree to participate in treatment planning, including formulating goals for treatment, and appropriate interventions which address my child's individual unique problems.

I am aware that my insurance carrier (CBH, Medicare or other insurance) has a right to access my clinical records for payment and monitoring purpose and I authorize the release of such information when appropriate.
I authorize COMHAR to bill my insurance carrier for any services rendered and I agree that I may be liable for any services which are not covered by my insurance.

All of the above information was explained to me and I have had an opportunity to have all my questions answered. I am aware of all the benefits and risks of treatment as explained to me, and I give my informed consent to treatment with COMHAR.

Participant or Parent/Legal Guardian Signature Date

Witness Signature Date

Participant or Parent/Guardian has accepted ☐ has not accepted ☐ a copy of this consent form.

COMHAR INC. Supporting Growth and Purpose Through Community	**ATTESTATIONS** *Revised 01/06/2021*

MENTAL HEALTH ADVANCE DIRECTIVE

Please check all that apply:

☐ I **have** executed an advance directive and will provide COMHAR with a copy of it as soon as possible.

OR

☐ I **have not** executed an advance directive.

AND

☐ I **would** like further information about advance directives and acknowledge receipt of COMHAR's Consumer Bulletin on Advance Directives.

OR

☐ I **would not** like further information about advance directives.

VOTER REGISTRATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes
☐ No

I ATTEST I HAVE BEEN OFFERED THE FOLLOWING INFORMATION/DOCUMENTS:

1) Mental Health Advance Directive Information
2) Voter Registration Information
3) COMHAR's Privacy Practices
4) Participant Rights & Responsibilities, and any Program Rules/Agreements
5) Consumer Grievance Procedures (which outlines the process if I have a grievance or complaint)
6) Naloxone Member Information Sheet (information on Naloxone & how to access Naloxone)

Participant Signature: Date:

Witness Signature: Date:

COMHAR Inc.
COMHAR-Family/Significant Person Release

Patient Name	Date of Birth	Gender	ID No.	Intake Date

Requirement Information

Entered With	Document	Expiration Date	Actual Date

Other Description

Responsibility

Staff Responsible	Program Providing Service	Facility

Request

Request Statement and Authorization

I understand that the purpose of this release is to provide communication between COMHAR Inc., myself, and the person's listed below. This information exchanged will provide an aid for my treatment and for my family's support.
I hereby request and authorize you to release the information indicated below to the following individuals:

Person 1

Name	Address	City State Zip	Phone

Permission to invite to treatment team meetings?

Person 2

Name	Address	City State Zip	Phone

Permission to invite to treatment team meetings?

You have my permission to verbally discuss the following information:

Scheduled Appointments	Treatment Program and Description	Medications and Side Effects	Admission to and Discharge from any facility
☐	☐	☐	☐

Services and Treatment Plan ***Progress and Obstacles to Progress*** ***Discharge Plan***

Other

Authorization

Statement of Authorization:

I hereby authorize the use and/or disclosure of any identifiable health information as described above.
I have been informed and understand the following:

1. I have a right to revoke this authorization by notifying the providing person and/or organization in writing, and that if I do revoke this authorization it will only affect release of further information. It will not apply to information already released.

2. I understand that there is a potential for the information authorized to be subject to disclosure by the recipient, and in some cases, will no longer be protected health information.

3. I understand that my health care will not be affected if I do not sign this authorization.

4. I have been informed of my right to examine/inspect the information to be released (subject to the restrictions of the client's access indicated in HIPAA§164.524 and Mental Health Procedures Act §5100.33)

5. I certify by my signature that I understand the nature of this authorization.

6. Photocopies, emails and facsimiles of this authorization shall carry the same authority as the original

Signatures

HIPAA Requirement

HIPAA requires that a copy of the consent be provided to the client or representative

Client has accepted a copy of this consent

Client has NOT accepted a copy of this consent

Signature of Client or Representative ***Date*** ***COMHAR witness (required for MH)*** ***Date***

PA Mental Health Verbal Authorization Only

Verbal Authorization

Two witnesses verify that the consumer understands the nature of the authorization and freely gives verbal consent. Individual is physically unable to provide signature

Witness ***Date*** ***Witness*** ***Date***

Additional Information

Remarks

Documents

Attached Document

Tasks/Schedules

Schedule Next

Next Scheduled Event

Event

Last Name	First Name	Event	Due Date/Time	Scheduled Date/Time	Staff

COMHAR
Supporting Growth & Purpose through Community

"It is a violation to alter documents once completed".

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION / Medical and Behavioral Health

Please read the information below carefully before signing this form. Print legibly in black ink only. **All fields must be completed.** Pursuant to state and federal laws, fees may apply.

Individual Name (First, Middle, Last)	Date of Birth	Last Four Digits of Social Security Number XXX-XX-
Home Address (Street, Apartment number)	City, State, Zip Code	
Telephone Number	Email address	

I, or my authorized representative, hereby authorize **COMHAR** to share my PHI as described below.

DATES OF SERVICE REQUESTED (list applicable dates of treatment)**:** _____

DESCRIPTION OF INFORMATION TO BE RELEASED: (check all items to be released)

☐ Psychiatric Evaluation ☐ Educational Assessment ☐ Psychological Assessment ☐ Consultation Reports

☐ Discharge Summary ☐ Progress Notes ☐ Psychological Evaluation ☐ Lab Results

☐ Imaging (Report or Study) ☐ Treatment Plans ☐ Medication Records ☐ Individual Service Plans

Other (please specify)**:** _____

SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE: I understand that in cases where my consent is legally required, the following information will not be released unless I specifically give permission by checking the box (es) below.

☐ *Substance Use (use, history, treatment). ☐ Sexual Assault ☐ Pregnancy ☐ Genetic

☐ Sexually Transmitted Diseases ☐ HIV/AIDS (13 yrs. and older) ☐ Behavioral or Mental Health

* Please specify the kind and amount of information that may be disclosed. Must be limited to information necessary to carry out the purpose(s) identified below: _____

PURPOSE OF RELEASE: ☐ At my request ☐ Continuity of Care ☐ Other (please explain): _____

REQUEST INFORMATION FROM: ☐ **INFORMATION TO BE PROVIDED TO:** ☐

Name of Person or Institution: _____

Street Address: _____ City/State/Zip Code _____

Phone: _____ Fax (if applicable): _____

FORMAT: ☐ M a i l ☐ F a x ☐ P i c k -Up ☐ Verbal Release

Secure Email (individual only). Provide email address: _____

You will receive an email from **COMHAR** *with instructions directing you to a secure site to retrieve your records.*

I understand that my authorization will automatically expire 365 days after the date of signature on this form, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____. I understand that I may revoke this authorization at any time by providing written notice to COMHAR. The revocation will be effective except to the extent COMHAR has already relied upon this authorization. Signing this authorization is voluntary. I understand that my refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing COMHAR to release information as described above. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. My signature acknowledges that I have read this form and/or have had it read to me. It has been explained in language that I can understand. I have received a copy of this authorization form and affirm that I am the person or am authorized to act on behalf of the person to sign this form verifying authorization for the use or disclosure of the protected health information under that above stated terms.

Signature: _____ **Date**: _____ **Time**: _____AM/PM

(Individual or Authorized Representative)

**If signed by anyone other than the individual, print name and relationship to individual below. Supporting documentation should be provided at the time of the request.*

Name: _____ **Relationship to Individual:** _____

NOTICE TO RECIPIENT OF INFORMATION

If the individual or their legally authorized representative authorized release of "Substance Use" information, as indicated by checking the designated boxes above on this form, the following Notice applies to the information you have received pursuant to this authorization: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

If the patient or legally authorized representative authorized release of "Behavioral or Mental Health Treatment", as indicated by checking the designated boxes above on this form, the following Notice applies to the information you have received pursuant to this authorization: This information has been disclosed to you from records protected that prohibits you from making any further disclosure of these records without the authorization of the patient, or as otherwise provided by law.

Supporting Growth and Purpose Through Community

Mental Health Advance Directive Supports

Pennsylvania law requires that we ask if you have a mental health advance directive. If requested, COMHAR will provide you written information describing your right to express preferences for mental health treatment and other decisions in the event you are incapacitated by mental illness.
COMHAR does **not** require you to have an advance directive in order to receive mental health services. COMHAR will obey the instructions in your advance directive to the extent permitted by law. If you are interested in having an advance directive, these agencies are available to help:

Pennsylvania Mental Health Consumers' Association
1-800-88PMHCA
pmhca@pmhca.org

Pennsylvania Protection & Advocacy / Disabilities Law Project
1-800-692-7443
717-236-8110
1-877-375-7139 (TDD/TTY)

Mental Health Association in Pennsylvania
1-866-578-3659
717-346-0549
info@mhapa.org

Voter Registration Information

If you have questions about registering to vote, you can call 1.877.VOTESPA (1.877.868.3772)

You can register to vote here: **https://www.pavoterservices.pa.gov/Pages/VoterRegistrationApplication.aspx**

If you apply to register to vote, the office at which you submit this registration application will remain confidential. No information relating to a declination to register to vote will be used for any purpose other than for voter registration. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

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

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

COMHAR INC.
Supporting Growth & Purpose through Community

Privacy Policy

Notice of Privacy Practices

Regarding the use and disclosure of treatment information

This Notice Describes How Health Information about You May Be Used and Disclosed and How You Can Get Access to This Information.

Please Review It Carefully. Changes On This Notice Will Not Be Honored.

YOU WILL BE ASKED TO ACKNOWLEDGE THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES.

For over forty-five (45) years, respecting and protecting consumer privacy has been one of the highest priorities for COMHAR. By explaining our Privacy Policy to you, we trust that you will better understand how we keep any information regarding your treatment private and confidential.

We understand that information about you and your health is very personal. Therefore, we strive to protect your privacy as required by law. We will only use and disclose your personal health information ("PHI") as allowed by law. We are committed to excellence in the provision of state-of-the-art health care services through the practice of patient care, education, and research. Therefore, as described below, your health information will be used to provide you care and may be used to educate health care professionals and for research purposes. We train our staff and work force to be sensitive about privacy and to respect the confidentiality of your PHI.

We are required by law to maintain the privacy of our patients' PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice ("Notice") so long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new notice effective for all PHI maintained by us. You may receive a copy of any revised notice at any of our hospitals, doctors' offices, or ambulatory care facilities.

The terms of this Notice apply to COMHAR, and the physicians, licensed professionals, employees, volunteers, and trainees seeing and treating patients at each of these care settings.

If you have questions regarding the coverage of this Notice, or if you would like to obtain a copy of this Notice, please contact the COMHAR Privacy Office as described below.

USES AND DISCLOSURES OF YOUR PHI

The following categories describe the ways we may use or disclose your PHI without your consent or authorization. For each category, we will give you illustrative examples.

Uses and Disclosures for Treatment, Payment and Health Care Operations.

Treatment: We use and disclose your PHI as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care – within and outside of COMHAR – may use information in your medical record that may include procedures, medications, tests, etc. to plan a course of treatment for you.

Payment: We use and disclose your PHI as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services

provided to you. Also, we may use your information to prepare a bill to send to you or to the person responsible for your payment.

***Health Care Operations**:* We use and disclose your PHI for health care operations. This is necessary to operate COMHAR, including by ensuring that our patients receive high quality care and that our health care professionals receive superior training. For example, we may use your PHI to conduct an evaluation of the treatment and services we provide, or to review the performance of our staff. Your health information may also be disclosed to doctors, nurses, staff, medical students, residents, fellows, and others for education and training purposes.

The sharing of your PHI for treatment, payment, and health care operations may happen electronically. Electronic communications enable fast, secure access to your information for those participating in and coordinating your care to improve the overall quality of your health and prevent delays in treatment.

***Health Information Exchanges**:* COMHAR participates in initiatives to facilitate this electronic sharing, including but not limited to Health Information Exchanges (HIEs) which involve coordinated information sharing among HIE members for purposes of treatment, payment, and health care operations. Patients may opt-out of some of these electronic sharing initiatives, such as HIEs. COMHAR will use reasonable efforts to limit the sharing of PHI in such electronic sharing initiatives for patients who have opted-out. If you wish to opt-out, please contact your patient services associate.

Persons Involved In Your Care. Unless you object, we may, in our professional judgment, disclose to a member of your family, a close friend, or any person you identify, your PHI, to facilitate that person's involvement in caring for you or in payment for your care. We may use or disclose your PHI to assist in notifying a family member, personal representative or any person responsible for your care of your location and general condition. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts to locate a family member or other persons who may be involved in some aspect of caring for you.

Fundraising. We may contact you, at times in coordination with your physician, to donate to a fundraising effort on our behalf. If we contact, you for fundraising purposes, you have the right to opt-out of receiving any future solicitations.

Appointments and Services. We may use your PHI to remind you about appointments or to follow up on your visit.

Health Products and Services. We may, from time to time, use your PHI to communicate with you about treatment alternatives and other health-related benefits and services that may be of interest to you.

Research. We may use and disclose your PHI, including PHI generated for use in a research study, as permitted by law for research, subject to your explicit authorization and/or oversight by Institutional Review Boards (IRBs), committees charged with protecting the privacy rights and safety of human subject research, or a similar committee. In all cases where your specific authorization has not been obtained, your privacy will be protected by confidentiality requirements evaluated by such a committee. For example, the IRB may approve the use of your health information with only limited identifying information to conduct outcomes research to see if a particular procedure is effective. COMHAR supports research and may contact you to invite you to participate in certain research activities. If you do not wish to be contacted for research purposes, please inform your patient services associate. In such case, we will use reasonable efforts to prevent this research-related outreach. This will not apply to the use of your PHI for research purposes as described above and will not prevent your care providers from discussing research with you.

Business Associates. We may contract with certain outside persons or organizations to perform certain services on our behalf, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. In such cases, we require these business associates, and any of their subcontractors, to appropriately safeguard the privacy of your information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your consent or authorization. Subject to conditions specified by law, we may release your PHI:

- For any purpose required by law;
- For public health activities, such as required reporting of disease, injury, birth and death, and for required public health investigations;
- To certain governmental agencies if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect, or domestic violence;
- To entities regulated by the Food and Drug Administration, if necessary, to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety. In most cases you will receive notice that your PHI is being disclosed to your employer;
- If required by law to a government oversight agency conducting audits, investigations, inspections, and related oversight functions;
- In emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- If required to do so by a court or administrative order, subpoena, or discovery request. In most cases you will have notice of such release;
- To law enforcement officials, including for purposes of identifying or locating suspects, fugitives, witnesses, or victims of crime, or for other allowable law enforcement purposes;
- To Mental Health Review Officer in the course of legal proceedings authorized by statute or regulations
- To coroners, medical examiners, and/or funeral directors;
- If you are a member of the military for activities set out by certain military command authorities as required by armed forces services. We may also release your PHI, if necessary, for national security, intelligence, or protective services activities; and
- If necessary for purposes related to your workers' compensation benefits.

Your Authorization. Except as outlined above, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure. The form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke your authorization in writing, except to the extent we have already relied upon it. These situations can include:

- Uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes, including marketing communications paid for by third parties;
- Uses and disclosures of PHI specially protected by state and/or Federal law and regulations;
- Uses and disclosures for certain research protocols;
- Disclosures that constitute a sale of PHI.

Confidentiality of Alcohol and Drug Abuse Patient Records, HIV-Related Information, and Mental Health Records. The confidentiality of alcohol and drug abuse treatment records, HIV-related information, and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in limited and regulated other circumstances.

RIGHTS THAT YOU HAVE

Access to Your PHI. If you are of appropriate legal capacity and understand the nature of treatment information and the purpose for which treatment information may be used or disclosed, you generally have the right to reasonable access or copies of certain PHI that we maintain about you. *Access* refers to the *physical examination* of treatment information but does not include physical possession of this information. Requests for access or copies must be made in writing and be signed by you or, when applicable, your personal representative. COMHAR may charge you for a copy of your medical records in accordance with a schedule of fees under federal and state law. COMHAR can provide you the appropriate release form, or you may obtain the appropriate form from the doctor’s office or any entity where you receive services. COMHAR reserves the right to limit or deny requests for access/copies based on the following:

1. There is compelling evidence that access may cause you substantial harm or detriment to the treatment process; and/or when disclosure of specific treatment information will reveal the identity of persons, or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality.
2. The limitations on access to treatment information are applicable to parents, guardians, and others who may otherwise have the right to control access over treatment records, except that the possibility of substantial detriment to the parent, guardian, or other persons may also be considered.
3. COMHAR retains discretion in reviewing the request for treatment information in advance of granting access or releasing records and may be present when the treatment information is being reviewed.

Amendments to Your PHI. You have the right to request that PHI that we maintain about you be amended or corrected. Requests for amendment must be made in writing and signed by you or, when applicable, your personal representative and must state the reasons for the amendment/correction request. We are not obligated to make all requested amendments but will give each request careful consideration. If we grant your amendment request, we may also reach out to other prior recipients of your information to inform them of the change. Please note that even if we grant your request, we may not delete information already documented in your medical record. You may obtain the appropriate form from the doctor's office or entity where you received services.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI, except for disclosures made for purposes of treatment, payment, and health care operations or for certain other limited exceptions. This accounting will include only those disclosures made in the six years prior to the date on which the accounting is requested. Requests must be made in writing and signed by you or, when applicable, your personal representative. The first accounting in any 12-month period is free; you will be charged a reasonable, cost-based fee for each subsequent accounting you request within a 12-month period. You may obtain the appropriate form from the doctor's office or entity where you received services.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations. We are not required to agree to your restriction request, unless otherwise described in this notice, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed to restriction if we believe such termination is appropriate. In the event we have terminated an agreed upon restriction, we will notify you of such termination. The appropriate form can be obtained from the doctor's office or entity where you received services and must be signed by you or, when applicable, your personal representative.

Restrictions on Disclosures to Health Plans. You have the right to request a restriction on certain disclosures of your PHI to your health plan. We are required to honor such requests for restrictions only when you or someone on your behalf, other than your health plan, pays for the health care item(s) or service(s) in full. Such requests must be made in writing and signed by you and, when applicable, your personal representative. You may obtain the appropriate form from the doctor's office or entity where you received services.

Confidential Communications. You have the right to request communications regarding your PHI from us by alternative means or at alternative locations and we will accommodate reasonable requests by you. You, or when applicable, your personal representative must request such confidential communication in writing to each department to which you would like the request to apply. You may obtain the appropriate form from the doctor's office or entity where you received services.

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

Paper Copy of Notice. As a patient, you have the right to obtain a paper copy of this Notice. You can also find this Notice on our website at: https://www.comhar.org/privacy-policy.

ADDITIONAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you may file a complaint in writing with the doctor's office, ambulatory care facility, or Guest Services department of the hospital/facility you visited. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, DC. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

For Further Information. If you have questions or need further assistance regarding this Notice, you may contact the COMHAR Privacy Office in the Office of Audit, Compliance and Privacy by telephone (215) 203-3000 or at 100 West Lehigh Ave, Philadelphia, PA 19133.

This Notice is effective June 19, 2020

COMHAR INC.

Supporting Growth and Purpose Through Community

Outpatient Participant

Rights, Responsibilities, and Rules

While receiving outpatient services at COMHAR, Participants have the following rights and responsibilities:

RIGHTS

1. The right to be treated with respect and dignity.
2. The right to receive quality mental health services provided by qualified professionals.
3. The right for information to be kept confidential. Only where permitted by law may information be released without a participant's consent (see COMHAR's Privacy Practices).
4. The right to informed consent. The right to full knowledge of the parameters of any services received, including any research study or medical procedure.
5. The right to withdraw from outpatient services/programs.
6. The right to clear explanations of services and treatment options in a language they can understand.
7. The right to access care in a timely fashion. If services are canceled or rescheduled by the program, the Participant will be offered the first available appointment or an accommodation, when clinically appropriate. Participants waiting for a provider to be assigned will receive outreach and be offered referrals/resources to address clinical needs. A temporary provider will be offered, whenever possible.
8. The right to be treated fairly without discrimination. If the Participant thinks they have been discriminated against due to race, sex, age, ethnicity, gender, religion, sexual orientation, or health status while receiving services, the Participant can file a grievance through the appropriate channels.
9. The right to access my treatment record as outlined in the COMHAR Privacy Practices.
10. The right to file a complaint or grievance. The grievance procedure is offered to all Participants and is posted in COMHAR's facilities.

RESPONSIBILITIES

1. Treat others with respect.

2. Complete documentation needed to participate in services.

3. Keep scheduled appointments. Contact the office/site in advance of missed appointments (at least 24 hours when possible). A pattern of missed appointments may result in delayed services or discharge from the program.

4. Arrive for appointments on time. Arriving late may result in the appointment being rescheduled and may be considered a missed appointment.

5. Actively participate in services: meet with therapist regularly, participate in treatment/recovery planning, and follow the plan of care agreed on by Participant and provider.

6. Participate while free from the influence of alcohol or non-prescribed, controlled substances.

7. Notify the program of updates to information including: insurance, phone number or address, emergency contacts, primary care provider, or clinical information (ex: medications, symptoms).

8. Report concerns about the quality of care, abuse or fraud.

9. Maintain appropriate behavior and agree to follow the Outpatient Program Rules listed below.

Outpatient Program Rules

1. **Respect yourself and others** (examples below)
   a. Speak with respectful words, tone of voice, volume and gestures.
   b. Abstain from using cameras or speakers.
   c. Abstain from aggressive, sexual, or abusive words or behaviors.
   d. Respect others' privacy.
   e. Refrain from solicitation/distribution.
   f. Please wear clothing appropriate for a therapeutic environment.

2. **Respect the environment/program** (examples below)
   a. Follow COMHAR's Weapon's Free Policy.
   b. Follow program procedures (ex: check in, remain in designated areas, wait your turn).
   c. Help maintain an alcohol and drug-free premises.
   d. Keep areas clean.
   e. Respect the Tobacco-Free environment.
   f. Refrain from loitering.

3. **All visitors are also responsible for following program rules and procedures.**

COMHAR INC.
Supporting Growth & Purpose through Community

Consumer Grievance Procedures

In accordance with COMHAR's Consumer Rights policy, COMHAR consumers or their legally responsible party, or a representative or provider acting on a consumer's behalf with the consumer or responsible party's written consent, have the right to file a verbal or written grievance (complaint) to COMHAR staff. Consumers are requested to address their concerns with Program Supervisor/Director/Manager, Division Director, or Chief Program Officer. If a resolution has not been reached consumers will be encouraged to utilize COMHAR's helpline (1-800-826-6762 or comhar.alertline.com) or other external grievance agency such as CBH, DBHIDS or to the Pennsylvania Department of Public Welfare, regarding dissatisfaction with service delivery or the quality of care provided. A consumer representative may include legal counsel, a relative, a friend, or another individual as spokesperson. If a consumer does not speak English, an interpreter will be provided to facilitate the grievance process. All grievances are kept confidential.

- COMHAR must discuss with and provide to the consumer in writing the specific steps, including time frames for response that will be taken to resolve the consumer's grievance.
- COMHAR staff will document and follow-up on all verbal and written grievances. The individual recording the grievance will document the date, time and identification of the consumer filing the grievance, the individual/staff recording the grievance, and a description of the grievance.
- COMHAR staff and business associates will adhere to the privacy standards of and will maintain the confidentiality of all consumer grievances.
- Grievance information is provided upon initial consumer visit and at least annually thereafter, and when a consumer files a grievance with COMHAR, as described in this policy under "process."
- Neither COMHAR nor its staff will retaliate in any way against anyone filing a grievance or providing information in regard to a grievance. COMHAR will give the consumer written information about the Grievance. COMHAR will continue to provide all required services to the consumer during the grievance process.
- COMHAR will provide linguistic or interpreter assistance in the event that a consumer is unable to understand and fully participate in the grievance process due to a cultural or linguistic reason.
- All COMHAR consumers will receive written notice of receipt of a grievance
- All COMHAR consumers will receive written notice of the grievance determination

NALOXONE Information Sheet

Updated 11/9/20

What is Naloxone?

Naloxone is an antidote to Opioid drugs such as Heroin Morphine, Hydrocodone, Oxycodone, and OxyContin. Naloxone is safe and effective. Naloxone also goes by the brand name of Narcan and Evzio.

How does Naloxone help?

Naloxone is an antidote to opioids. Opioids can slow, or stop a person's breathing, which can lead to death. Naloxone helps the person wake up and continue breathing. An overdose death may happen hours after using opiates. Upon noticing a person's breathing has slowed, or when the person will not wake up, call 911 immediately, start rescue breathing (if needed), and administer Naloxone.

How to administer Naloxone:

A bystander can safely and legally spray Naloxone into the nose or inject it into a muscle.
The "Good Samaritan" component of the "Opioid Antidote and Overdose Prevention Act" provides legal protections both civil and criminal, to the overdose victim and to the person administering Naloxone. When administering Naloxone, open the Naloxone kit, and follow the enclosed instructions. For a demonstration on how to properly administer Naloxone, you can use one of the links at the bottom of this page.

INTRANASAL NALOXONE:

Naloxone for nasal use is given with the application of an atomizer that is placed onto a syringe then placed into each nostril.

INTRAMUSCULAR INJECTION:

Naloxone can also be injected into the upper arm muscle (deltoid) or the outer thigh (gluteus). In an emergency, it is safe to inject through clothing. Naloxone works within 2-5 minutes. If the person does not wake up after 5 minutes, bystanders should administer a second dose. Rescue breathing should be done while you wait for the Naloxone to take effect.

What are the next steps following administration of Naloxone?

CALL 911 and stay with the individual. If you are in a position to help the overdose victim get into treatment for opioid addiction, learn about the available resources and encourage their treatment participation.

How do I get Naloxone?

Individuals who use opioids, family members and friends can access Naloxone by obtaining a prescription from their family doctor, COMHAR prescribers, or by using the standing order (a prescription written for the general public, rather than specifically for an individual) issued by Rachel Levine, M.D., PA Physician General. This PA standing order can be accessed through most PA pharmacies.

How can I receive more information or training?

https://www.pavtn.net/act-139-training
www.getnaloxonenow.org
https://www.youtube.com/watch?v=Bul_CB_9o-Y
http://prescribetoprevent.org/patient-education/videos/