Idaho State University

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

Patient Registration Form

Patient Information

Patient Information:

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

Additional Information and Responsible Party

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

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

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

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

Insurance Information

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

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

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

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Client Intake Information

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

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

CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

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

Biologic Sex: _____ Sexual Orientation: _____

Primary Language: _____

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

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

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

Email: _____
May email: ☐ Yes ☐ No

Current Occupation: _____ Level of Education Completed: _____

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

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

Have you received prior counseling or mental health treatment? ☐ Yes ☐ No

If yes, please explain:

_____

Was it helpful? ☐ Yes ☐ No Please explain: _____

What psychiatric medications have you tried in the past?

Medication Name	Strength	Directions	Prescriber	Outcome

PRESENTING PROBLEMS AND CONCERNS

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

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

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

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

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

Present Family/ Living Situation

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

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

HISTORY

Health

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

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

Medication Name	Strength	Directions	Prescriber

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

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

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

If yes to either, please explain: _____

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

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

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

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

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

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

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

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

Diagnosis	Provider who treats	Date diagnosed	How well controlled?

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

Diagnosis	Provider who treats	Date diagnosed	How well controlled?

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

Type of injury	Date	Treatment given?	Loss of consciousness?

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

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

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

Cultural Beliefs Affecting Treatment

What culture do you identify with?

Strengths and Interests

What are your strengths and interests?

GOALS

What are the goals you hope to achieve in treatment:

1.

2.

3.

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

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

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Agreement for Comprehensive Mental Health Services

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

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

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

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

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

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

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

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

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

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

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

- **No-Shows:** A 'no-show' is defined as missing an appointment without canceling or rescheduling at least 24 hours in advance. If a patient fails to show up for a scheduled appointment without prior notice, they will be marked as a no-show and charged a $20.00 no-show fee. Patients will be discharged and unable to receive services after 3 no-shows.
- **Cancellations:** Patients are required to provide at least 24 hours' notice if they need to cancel or reschedule an appointment. This allows us to offer the appointment slot to another patient who needs care. If a patient does not provide 24 hours' notice when cancelling or rescheduling an appointment, the appointment will be marked as a no-show, and the patient will be charged a $20.00 no-show fee.
- **Late Arrivals:** Patients arriving 10 minutes after the scheduled appointment time may be seen at their provider's discretion. Arrivals after 15 minutes will have to be rescheduled and will be counted as a no-show.
- **Communication:** It is the responsibility of the patient to ensure that the clinic has their current contact information on file. We will make every effort to remind patients of upcoming appointments via phone, email, or text message, but ultimately, it is the patient's responsibility to keep track of their appointments.

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

_____

Patient Name

_____ _____

Signature of Patient Date

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Consent for Treatment / Statement of Financial Responsibility

Consent for Treatment

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

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

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

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

Billing Policy

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

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

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

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

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

Photography/Other Images

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

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Email/Text Reminders

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

☐ Text ☐ Email: _____

☐ No reminders via text or email.

I have read and understand the content of this form.

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

_____
Signature of Patient or Personal Representative

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

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

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Controlled Substances Agreement

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

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

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12. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
13. I will not allow anyone else to have, use sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is against the law.
14. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
15. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.
16. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by physician.
17. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
18. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.
19. I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name of Physician

_____ _____
Signature of Physician *Date*

ISU Community Psychiatric Center
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Telehealth Patient Consent Form

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

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

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

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

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

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

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

_____ _____

Patient/Guardian Signature Date

Idaho State University

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Authorization to Obtain Emergency Medical Treatment

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

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

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

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

Idaho State University

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices from Idaho State University.

The Notice of Privacy Practices describes how my protected health information (PHI) may be used and disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law. It also explains my rights regarding my health information.

I understand that the University reserves the right to change its Notice of Privacy Practices and that a revised Notice will be made available upon request and posted as required by law.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Printed Name of Patient or Personal Representative: _____

Date: _____ Date of Birth: _____

Patient/Personal Representative Signature: _____

Relationship to Patient (if applicable): _____

Office Use Only (If Acknowledgment Not Obtained)

The Practice made a good faith effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained for the following reason:

☐ Patient declined to sign
☐ Emergency situation
☐ Communication barriers

☐ Other: _____

Staff Name: _____ Date: _____

Idaho State University

NOTICE OF PRIVACY PRACTICES

IDAHO STATE UNIVERSITY COVERED ENTITY HEALTH CARE CLINICS AND PHARMACIES

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.

Effective Date: This notice is effective February 15, 2026 and will remain in effect until updated or replaced as required by law.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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

To file a complaint if you feel your privacy rights have been violated, or if you would like to request a restriction, request an accounting of disclosures or revoke an authorization, please contact:

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

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.,
Washington, D.C. 20201,
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

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.

Share Information With Your Family, Close Friends or Others Involved in Your Care

You can tell us whether you want your information shared with family members or others involved in your care.

Share Information in a Disaster Relief Situation

You can tell us whether you want your information shared in disaster relief situations.

Marketing, Sale of Information, and Psychotherapy Notes

We will not share your information for marketing purposes, sale of your information or for most purposes involving psychotherapy notes without your written permission, unless the law allows

it. Psychotherapy notes are notes made by a mental health professional during counseling sessions and kept separate from your medical record.

Fundraising Communications

We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

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:

To Treat You

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To Run Our Organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We may use Artificial Intelligence (AI) tools to help manage and support your care.

Example: We use health information about you to manage your treatment and services.

To Bill for Your Services

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

Example: We give information about you to your health insurance plan so it will pay for your services.

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

Substance Use Disorder Records (42 C.F.R. Part 2)

Some types of health information are subject to additional protections, which are described below.

Health information we maintain may be protected by federal substance use disorder confidentiality regulations at 42 C.F.R. Part 2 ("Part 2 records"). If Idaho State University creates, receives, or maintains Part 2 records, the following additional protections apply:

- Part 2 records are subject to more restrictive confidentiality protections than other health information. Where this notice describes uses and disclosures permitted under HIPAA, those uses and disclosures may be further limited by Part 2.
- Part 2 records, or testimony that would identify you as having or having had a substance use disorder, will not be used or disclosed in any civil, criminal, administrative or legislative proceeding against you unless you provide written consent or a court order consistent with 42 C.F.R. Part 2 is obtained.
- If we intend to use Part 2 records for fundraising activities, we will first provide you with a clear and conspicuous opportunity to opt out of receiving any fundraising communications that would rely on those records.
- Participation in an organized health care arrangement does not eliminate or reduce the confidentiality protections that apply to Part 2 records.
- For questions about Part 2 records or to opt out of fundraising communications involving Part 2 records, contact ISU's HIPAA Compliance Officer using the contact information listed in this notice.

Business Associates

We may share your information with businesses that help us run our organization or provide services to you. These entities are required to protect your information.

For Education

Students, interns, residents, instructors and trainees may see your information while providing supervised care. Their access is limited and protected under HIPAA and our own privacy rules.

For Research

We may use or share your health information for research when allowed by law. This may include research reviewed and approved by an Institutional Review Board (IRB) or similar research review board. We may also store information for research or use or share it for future research. When required by law, we will ask for your written permission to use or share your information for a specific research project.

We may also use or share information that has been de-identified so that it can no longer identify you.

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.

Parental Access

Some state laws concerning minors permit or require disclosure of health information to patients, guardians or persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.

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.

Telehealth Services

If you receive services by telehealth, we will protect your information under HIPAA and any applicable state laws. Telehealth may use technology vendors that must meet privacy and security requirements.

Email and Text Communications

If you choose to receive information by email or text message, you should know that these communications may not always be encrypted. You can ask us to stop or request another communication method at any time.

Electronic Communications / Portals

By using our patient portal, telehealth services or receiving emails or text messages from us, you agree to electronic communication. You may request alternative communication methods at any time.

Re-Disclosure Notice

If we disclose your information to someone who is not required to follow HIPAA, that information may no longer be protected.

Part 2 records cannot be re-disclosed without your written permission unless the law allows it.

Telepharmacy Services

Our pharmacy will use telepharmacy to provide safe, accessible pharmaceutical care to patients in underserved areas of Idaho. All telepharmacy operations will comply with Idaho Board of Pharmacy regulations, including remote pharmacist supervision, certified technician staffing and secure technology for dispensing and patient counseling.

Pharmacy Confidentiality

Idaho law gives extra protections to pharmacy records. Prescriptions and related records must be kept confidential and may only be shared with certain parties or as required by law. These records generally cannot be shared again unless the law allows it.

Refill and Medication Communications

Communications about current prescriptions or refill reminders are not considered marketing and may be provided without your written permission.

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. You may revoke that permission at any time by notifying us in writing.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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 website. You may obtain a copy of this notice at any time and we will provide it to you free of charge.

Hybrid Entity Designation

Idaho State University is a hybrid covered entity. This notice applies only to our clinic and pharmacy components that are designated as covered entity components under HIPAA and provide health care services as part of Idaho State University. Other components of the university are not included in this notice.

A current list of HIPAA covered clinics is available upon request by contacting the HIPAA compliance officer at (208) 282-4380 or by emailing hipaa@health.isu.edu.

State Law Compliance

We follow applicable state laws that provide additional privacy protections or greater access to health information. Where state law is more protective than HIPAA, we will comply with the more protective standard unless federal law or a specific HIPAA provision prohibits it.

Website and Online Privacy

Idaho State University maintains a separate University Privacy Notice that explains how the university collects and uses information on its websites, including cookies and other online technologies. This NPP does not replace that notice. For information about website cookies and online privacy practices, please see our Privacy Policy at www.isu.edu/ogc/privacy.