ORIENTATION CHECKLIST

Client Name ____________________________ Admission Date___________

Date/Staff Initials

Date/Staff Initials	
	Client Handbook received. (p. 13-18)
	Review hours of operation and after-hours access. (p. 13)
	Explanation of fees, payment responsibilities, cancellation policy. (p.13 & 14)
	Copy of Sliding Fee Scale (if applicable). (p. 6)
	Assessment and Treatment Planning process reviewed. (p. 14)
	Client Rights Acknowledged and reviewed. (HIPAA p. 9-11 & Treatment p.15-16)
	Explanation of service confidentiality. (p. 16-17)
	Grievance Procedures reviewed. (p. 17)
	Review of on-site policies. (p. 18) Non-Smoking; Drug, Alcohol, and Medications; Firearms/Weapons; Seclusion and Restraint; and Safety.
	All Consents reviewed and completed with appropriate signatures and initialed. (p. 4-5)
	Medical Emergency Release reviewed and completed with appropriate signatures. (p. 4)
	Notice of Privacy Practices/Acknowledgement of Receipt signed & copy received. (p. 8-11)
	Review expectations of client.

I have participated in the review of the above Orientation items and have had all of my questions answered. I understand that I am encouraged to ask for additional information if I have further questions.

______________________ __________ ______________________ __________

Client/Guardian Signature Date Clinician Signature Date

Admission Form

For Office Use Only

First Date of Contact ___/___/___ Admission Date ___/____/____ Client Number:___________

Fee:_________ Clinician Name:_______________ ___Open ___Re-Admit ___Evaluation only

PLEASE FILL OUT ALL PAGES AS COMPLETELY AS POSSIBLE

Client Name: ____
(Last) (First) (Initial) (Maiden)

Mailing Name: ____
(To Whom **Bill** Is Addressed)

Address: __________________________________ ______________________________________
(P.O. Box/ Mailing Address) (City) (State) (Zip Code)

__________________________________ __________________________________
(Physical/street address) (City) (State) (Zip Code)

Date of Birth: ___/___/___ **Social Security Number:** __________________ **Current Age:** _____
Place of Birth: City______ State____ County_____ Country_____

(choose one) Gender: Male ___ Female ___ Gender Neutral____ **Mother's First Name**____________________

County/State where problem first originated: ____

Telephone: Home: ( ) ______________ Work: ( ) _______________ Cell/Other: ( ) ______________

May we call you at: Home: Yes No Work: Yes No Cell: Yes No
May we leave a message at: Home: Yes No Work: Yes No Cell: Yes No

Marital Status:
Never Married___
Divorced ___
Widowed ___
Separated ___
Married ___
Living as Married___
Minor Child (under 18)___

Military Status:
Combat Veteran:_____
Non-Combat Veteran:_____
Active Duty:____
Not a Veteran: _____

Have you been arrested in the last 90 days? ___Yes ___No

Have you been arrested in the last 30 days? ___Yes ___No

Are you currently on: Probation: ___Yes ___No
Parole: ___Yes ___No

Highest Grade Level Completed: *(circle one)* none Preschool 1 2 3 4 5 6 7 8 9 10 11 12 High School/GED
1 Year College 2 Years College/Associates Degree 3 Years College Bachelors Degree Masters Degree Doctoral Degree

Have you been suspended from school in the last 30 days?___Yes ___No ___Not School-Aged

Ethnic Background:
____ White
____ Black
____ Native American/Alaskan
____ Hispanic
____ Asian
____ Native Hawaiian/P. Islander
____ More than one race reported

Hispanic:
____ Cuban
____ Mexican
____OtherHispanic
____ Puerto Rican
___ Not of Hispanic Origin

Source of Referral:
____ Self
____ Family
____ Physician
____ DFS
____ Schools
____ Other:______________

Primary Source of Income:
____ Self
____ Family
____ SSI
____ SSDI
____ Other/Unemployment
____ Other/Disability
____ DFS
____ Retirement

Employment Status:
____ Unemployed
____ Part Time (<30 hrs)
____ Full Time (>30 hrs)
____ Retired
____ Disabled
____ Child (14 & under)
____ Student
____ Homemaker
____ Inmate Institution

Do you have a personal representative, conservator, guardian, or representative payee?
___Yes ___No
Name: ______________________
Address:_____________________
____
Phone:______________________

Occupational History:
Current Occupation: ____
Employer:____
How Long at Current Job? ____________

Gross Family Income:

$____________________Annually Number of people in household supported by family income: ___________

Who is your Primary Care Physician? ____

Have you seen your physician in the last year? **____Yes ____No**

Medication currently being taken:____

Current and significant chronic medical problems:____

Have you smoked tobacco in the last 30 days? ___Yes ___No ___Never Smoked

Briefly explain why you are requesting services at this time:_________________________________

____

Which of the following best represents your presenting problem(s) #1, #2, #3, etc?:

___Marital/Family, ___Social, ___Coping,___ Medical, ___ Mood Disorder, ___ Suicidal,

___ Alcohol, ___Drugs, ___ Criminal Justice System, ___ Eating Disorder, ___ Thought Disorder,

___ Abuse/Assault/Rape, ___Runaway ___ Perpetrator, ___ Court Ordered Evaluation

Please give relationship and age of others living at home including Guardians:________________

____

____

Insurance/Medicaid Information:____
(Company Name) (Policy #)

____
(Insured Name) (SS#) (DOB)

____
(Policy Effective Date) (Group #)

(OFFICE USE ONLY) **Copy of Insurance card(s):** _____ **Proof of Income**______

Co-Pay___________ **Deductible** __________ **Number of Approved Sessions** _____

Verification/Authorization # _________ **Office Staff Signature** _______________________

Financial Agreement

Thank you for allowing High Country Behavioral Health (HCBH) the privilege of serving you. High Country Behavioral Health does not discriminate in the provision of services to individuals based on their inability to pay, race, color, sex, national origin, disability, religion, or sexual orientation. Services will not be denied if a client does not have the ability to pay or method of payment. The following information explains your responsibilities under this agreement. If you have any questions, please do not hesitate to ask.

Fees

We accept Wyoming Medicaid, health insurance, cash, personal checks, EAP's, Visa/MasterCard, etc. to cover our usual and customary fees. We also offer a sliding fee scale for persons who demonstrate an inability to pay. Sliding fees are determined by income, and family size, and proof of household income is required. If you have any questions about your fee, please ask your therapist or the office manager.

Payment

It is the policy of HCBH to ask clients to make full payment at the time of service. When payment is not made at the time of service, HCBH will bill clients for services rendered. Payment plans can be arranged with the Clinical Director. Deferred payment plans can be arranged through the Clinical Director when necessary. Clients are encouraged to inquire when they believe a charge is not warranted. Clients will not be refused service based solely on inability to pay. Refusal to pay, in spite of ability, however, may result in termination of services. HCBH charges a fee of $25.00 for all returned checks or other NSF notifications.

Health Insurance

If you have health insurance, and if you request that this resource be utilized to pay for services, HCBH will bill that insurance with your approval. We will bill your insurance company our full usual and customary rate. If your health insurance requires pre-authorization for services it is your responsibility to coordinate this with your insurance company. You will be responsible to make your full payment if you have not met the deductible outlined by your insurance. You will also be responsible, at the time of services, for all co-payment amounts. HCBH will charge the usual and customary fee for services until it is determined that you do qualify for the sliding scale fee. By signing below, you agree to pay the usual and customary fee for services if your provider is not eligible for reimbursement by your insurance company.

Missed Appointments

A fee will be charged for missed appointments. Clients who fail to attend their appointments or cancel without 24 hour notification will be charged a $25.00 NO-SHOW FEE. If this is a repeated problem or if clients would like a session sooner than the next available appointment they will be encouraged to access counseling services during the next convenient WALK-IN CLINIC. *(where applicable)* This is a standard flat fee regardless of whether you are currently being charged the usual and customary fee or if you have qualified for the sliding fee scale and will not be billed to your insurance company or other third party payer source.

Debt Collection Services & Returned Check Fee

In extreme cases, and as a last resort, Debt Collection services will be utilized to pursue the collection of fees from responsible third parties and/or individual clients. Clients will be informed by mail before their accounts are turned over to collections. Accounts will be considered delinquent when a client has failed to make payments or payment arrangements for more than 60 days unless prior arrangements have been made with the primary clinician. There will be a returned check fee of $25 will be assessed for all returned checks.

Claims Processing

I authorize release of information necessary to process insurance claims (including private carriers and Medicaid) and authorize direct payment of benefits to High Country Behavioral Health. If payment is made directly to me, I hereby agree to promptly remit such payment to HCBH. I understand that insurance is a contract between me, my employer, and/or the insurance company. High Country Behavioral Health is not a party to the contract with your insurance company. I understand that not all services are a covered benefit in all insurance contracts and that I will be responsible for payment should any services not covered by my insurance.

Authorization for Billing:

I acknowledge that I have read and understand the financial agreement and my responsibilities for payment and agree to abide by all of its terms and conditions.

Client/Guardian Initials ___________ Date ___________

Medical Emergency Release:

According to 42 CFR Part 2, and CFR 45 part 164.510 a Medical Emergency is a situation that poses an immediate threat to the health of an individual (it need not be the client) and requires immediate medical intervention.

Without prior written consent the staff are not authorized to notify family or significant others unless there is specific authorization from the client consenting to this release of information. When using or disclosing protected health information HCBH will make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. (45 CFR 164.502)

In case of a medical emergency, I give written consent for High Country Behavioral Health staff to contact:

______________________________	________________	____________
Name	Relationship	Phone Number
______________________________	________________	____________
Name	Relationship	Phone Number

Client/Guardian Initials ___________ Date ___________

Consent to Video/Audio-tape:

To help assure the high quality of services and training in the treatment program, therapy sessions may be video or audio taped for training purposes. If and when this occurs you will be notified and be asked for your active consent. By initialing you consent to this type of observation for these purposes.

Client/Guardian Initials ___________ Date ___________

Informed Client Consent for Electronic Messaging

Unsecured Electronic Messaging may be used with clients for communicating PHI that has minimal privacy-related consequences such as appointment reminders and notification of services.

High Country Behavioral Health can respond to electronic queries but is not obligated to respond electronically and such responses must be conducted with care. To respond to you electronically you must provide your consent, recognizing that email, for example, is not a secure form of communication. There is some risk that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. HCBH will use the minimum necessary amount of protected health information to respond to your query.

In addition to this informed consent any correspondence between a client and their clinician will require the clinician to respond to your request with the authorization below:

I acknowledge that I understand the risks associated with electronic messaging and consent to its use, as minimally necessary.

The email address I give consent to use in electronic communication is______________________________________

Client/Guardian Initials ___________ Date ___________

Informed and Voluntary Consent for Treatment

Persons are served under the guidelines of informed consent. Persons served have an opportunity to be informed participants in their treatment decisions. It is generally accepted that complete informed consent includes a discussion of the following elements: the nature of the diagnosis, reasonable alternatives to the proposed treatment or intervention, the relevant risks, benefits, and uncertainties related to each alternative, assessment of client understanding, and the acceptance of the intervention/diagnosis by the client.

By signing below, I certify that I have reviewed, understand, and agree to the content of the following sections of this document: Financial Agreement, Consent for Release of Social Security Number, Medical Emergency Release, Consent to Video/Audio-tape, Informed Client Consent for Electronic Messaging, and Informed and Voluntary Consent for Treatment.

I have been given the opportunity to question the above consents and releases of information.

______________________________ ____________________________________ _______________
Client Printed Name Client Signature Date

______________________________ ____________________________________ _______________
Parent/Guardian Printed Name Parent/Guardian Signature Date

______________________________ ____________________________________ _______________
Witness Printed Name Witness Signature Date

HIGH COUNTRY BEHAVIORAL HEALTH
A New Way of Thinking

2018-2019 HIGH COUNTRY BEHAVIORAL HEALTH SLIDING FEE SCALE

When a client does not have insurance we use the following steps to calculate hourly rates for group, individual and psychiatric services.

Step 1: Collect the past two months pay stubs and previous year's tax return (page one of the 1040) and attach to this form.
Step 2: Deduct $368 per dependent from monthly gross income (or $4420 for annual income) prior to computing fee.
Step 3: Circle the monthly or annual gross income after making the appropriate deductions per dependent.
Step 4: Circle the hourly rate for Individual/Family/Case Management/Individual Rehab Services/Psychiatric services on the table.

Monthly Gross Income	Annual Gross Income	% Poverty	Individual/Family Case Mngt/Assessment per Hour	Group 6+ Hours/week	Group <6 Hours/week	Individual Rehab Services per Hour	Psychiatric Services (per 1/2 hour sessions)
<$500	<$6,000	100%	$0.00	$0.00	$0.00	$0.00	$0.00
$501-$868	$6,001-$10,420	100%	$2.00	$0.50	$1.00	$1.00	$2.00
$869-$1,236	$10,421-$14,840	150%	$5.00	$1.25	$2.50	$2.50	$5.00
$1,237-$1,604	$14,841-$19,260	200%	$10.00	$2.50	$5.00	$5.00	$10.00
$1,605-$1,972	$19,261-$23,680	250%	$15.00	$3.75	$7.50	$7.50	$15.00
$1,973-$2,340	$23,681-$28,100	300%	$20.00	$5.00	$10.00	$10.00	$20.00
$2,341-$2,708	$28,101-$32,520	350%	$25.00	$6.25	$12.50	$12.50	$25.00
$2,709-$3,076	$32,521-$36,940	400%	$30.00	$7.50	$15.00	$15.00	$30.00
$3,077-$3,444	$36,941-$41,360	450%	$35.00	$8.75	$17.50	$17.50	$35.00
$3,445-$3,812	$41,361-$45,780	500%	$40.00	$10.00	$20.00	$20.00	$40.00
$3,813-$4,180	$45,781-$50,200	550%	$45.00	$11.25	$22.50	$22.50	$45.00
$4,181-$4,548	$50,201-$54,620	600%	$50.00	$12.50	$25.00	$25.00	$50.00
$4,549-$4,916	$54,621-$59,040	650%	$60.00	$15.00	$30.00	$30.00	$60.00
$4,917-$5,284	$59,041-$63,460	700%	$70.00	$17.50	$35.00	$35.00	$70.00
$5,285-$5,652	$63,461-$67,880	750%	$80.00	$20.00	$40.00	$40.00	$80.00
$5,653-$6,020	$67,881-$72,300	800%	$90.00	$22.50	$45.00	$45.00	$90.00
$6,021-$6,388	$72,301-$76,720	850%	$100.00	$25.00	$50.00	$50.00	$100.00
$6,389-$6,756	$76,721-$81,140	900%	$110.00	$27.50	$55.00	$55.00	$110.00
$6,757+	$81,141+		$120.00	$30.00	$60.00	$60.00	$120.00

Hourly Rate for Group: $___________________________
Hourly Rate for Individual/Case Mangement/Couples/Family Services: $__________________________________
(there is a $25 NO SHOW FEE when failing to cancel a service 24+ hours prior to the service.)
(there is a $25 Return Check Fee for any returned checks)

______________________________ ____

Client Signature Date Therapist Signature Date

The fee scale above indicates the fees that will be charged for services. High Country Behavioral Health does not discriminate in the provision of services to individuals based on their inability to pay, race, color, sex, national origin, disability, religion, or sexual orientation. No one will be denied access to services due to inability to pay or method of payment. However, services may be denied to clients who refuse to pay according to an agreed upon payment plan. The maximum rate in each catergory will be charged until proof of HOUSEHOLD INCOME is received and a new fee is agreed upon. Household income will be verified by our business office through the past month's pay stubs and first page of the previous year's tax return (attached to this form.)

HEALTH ADVISEMENT

The incidence of Tuberculosis (TB), Hepatitis, Sexually Transmitted Diseases (STD), and HIV has increased among individuals in specific risk categories including alcoholics, drug-dependent individuals and those who have been jailed or hospitalized. **Testing is optional,** but it is in your best interest to be tested for Tuberculosis, Hepatitis, STDs and HIV if you think you may be at risk. A simple screening test is all that is required.

You can get an appointment for a screening test for TB ($5), Hepatitis (no charge) and HIV (no charge) at your local public health office:

Afton Public Health, 421 Jefferson, Suite 401, 885-9598
Kemmerer Public Health, Lincoln County Court House, 925 Sage Ave, 877-3780
Pinedale Public Health, Medical Clinic Building, 619 East Hennick, 367-2157
Evanston Public Health, 350 City View Drive, Suite 101, 789-9203

Testing for STDs can be arranged through your local physician. We would be happy to help you get an appointment if you need assistance.

I, ____________________________________, have read (or had someone read to me) and understand the above information.

_______________________________________ _________________________________

Client Signature Date

Notice of Privacy Practices

This notice describes how information about you obtained during the course of treatment may be used and disclosed and how you can obtain access to this information. Please review it carefully.

High Country Behavioral Health does not discriminate in the provision of services to individuals based on their inability to pay, race, color, sex, national origin, disability, religion, or sexual orientation. Services will not be denied if a client does not have the ability to pay or method of payment. If you have any concerns regarding the provision of services on the basis of handicap, you may contact Kipp Dana, Executive Director (307)885-9883.

Health information which we receive and/or create about you, personally, in this office, relating to your past, present, or future health, treatment, or payment for health care services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR parts 160 & 164. The confidentiality of alcohol and drug abuse records maintained in our programs is protected by another Federal law commonly referred to as the Alcohol and Other Drug Confidentiality Law, 42 CFR part 2. Generally, our programs may not say to a person outside the program that you attend the program, disclose any information indentifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal law. Your health information is further protected by any pertinent state law that is more protective or stringent than either of these two Federal laws.

Uses and disclosures that may be made of your health information:

•. **Internal Communications:** Your protected health information will be used within our program, which is between and among program staff who have a need for the information in connection with our duty to diagnose, treat, or refer you for substance abuse or other more appropriate courses of treatment. This means that your protected health information may be shared between or among personnel for treatment, payment or other care related operational purposes. For example: Two or more providers within the program may consult with each other regarding your best course of treatment. The program may share your protected health information in a billing effort to receive payment for health care services rendered to you. And/or, your protected health information may be discussed within the program about your treatment in connection with others in the program, in an effort to improve the overall quality of care provided by our program. Your protected health information will not be redisclosed by program personnel except as is otherwise permitted herein.

• **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of this program, that assist our program in providing care. Examples of qualified service organizations and/or business associates include billing companies,

data processing companies, or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this program through terms detailed in a written agreement.

• **Medical Emergencies:** Your health information may be disclosed to medical personnel in a medical emergency, when there is an imminent and immediate threat or danger to the health and safety of an individual, and when immediate medical intervention is required.

• **To Auditors and Evaluators:** This program may disclose protected health information to regulatory agencies, funders, third-party payers, and peer review organizations that monitor our programs to ensure that the program is complying with regulatory mandates and is properly accounting for and disbursing funds received.

• **Authorizing Court Order:** This program may disclose your protected health information pursuant to an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determinations as outlined in the Federal regulations and limits the scope of the disclosure.

• **Crime on Program Premises or Against Program Personnel:** This program may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the program premises or against program personnel.

• **Reporting Suspected Child Abuse and Neglect:** This program may report suspected child abuse or neglect as mandated by state law.

• **As Required By Law:** This program will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

• **Appointment Reminders:** This program reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

• **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice will be made only with your written authorization or that of your legal representative. If you or your legal representative authorize us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on the authorization.

Your rights regarding protected health information we maintain about you:

• **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit your request in writing to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing, or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial to any part or parts of your request. Some denials, by law, are reviewable, and you will be notified

regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in the law, are not reviewable. Each request will be reviewed individually, and a response will be provided to you in accordance with the law.

• **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for us; or
- Is not part of the protected health information which you would be permitted to inspect and copy.

If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial and/or how you may request that your request to amend and a copy of the denial be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.

• **Right to an Accounting of Disclosures:** You have the right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment, or other care related operations within our programs. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions:** You have the right to request a restriction or limitation on protected health information we are permitted to use or disclose about you for treatment, payment or other care related operations within our programs. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your mental health.

• **Right to Request Confidential Communications:** You have the right to request that we communicate with you about protected health information in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must

make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with any office of High Country Behavioral Health, please contact Kipp Dana, Executive Director, PO Box 376 Afton WY. 83110. You will not be penalized or otherwise retaliated against for filing a complaint**.** If you have questions as to how to file a complaint please contact us at 307-885-9883.

Our responsibilities:

This office is required to:

- Maintain the privacy of your protected health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your protected health information; and,
- Abide by the terms of this Notice while it is in effect.
-

This office reserves the right to change the terms of this Notice at any time and to make a new Notice with provisions effective for all protected health information that we maintain. In the event that changes are made, this office will notify you of a revised Notice by mail at the current address provided on your clinical record.

To receive additional information:

For further explanation of this notice you may contact Mr. Kipp Dana, privacy officer, at 307-885-9883.

You have a right to receive a copy of this notice, and all individuals receiving care will be given a hard copy.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of the High Country Behavioral Health Treatment Program.* We encourage you to read it in full.

If you have any questions about our *Notice of Privacy Practices,* please contact:

Privacy Officer: Kipp L. Dana
P.O. Box 376
Afton, WY 83110
(307) 885-9883

I ____acknowledge receipt of the *Notice of*
(Print client or participant's name)
Privacy Practices of High Country Behavioral Health.

Signature: ____ Date: ____________________________
Client/parent/guardian)

(Copy to client or participant and in client or participant file)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

If individual DID receive the Notice of Privacy Practices but did not sign this acknowledgement of receipt, state efforts and the reason why (refused, unable, left too soon, other reason):

If individual did NOT receive the Notice of Privacy Practices explain why (emergency treatment, patient declined receipt, other):

DISCHARGE STATEMENT

High Country Behavioral Health strives to offer you the best possible personal treatment/care.

When we begin treatment, there is a mutual understanding that there will also, at some point, be an end to treatment. This is a discussion and mutual understanding with your therapist regarding when therapy is complete. This is called a Discharge Plan. It will include a summary of services and treatment provided to you, the outcomes of treatment, if the treatment plan goals were met and the reason for discharge as well as aftercare options (including symptoms to watch for and options that are available if additional services are needed

Therapy is a collaborative effort. It is most beneficial for the client and therapist to decide together when treatment is complete and to discuss the best treatment options.

However, there are times when therapy will end prematurely with little opportunity for the therapist and client to assess to what degree therapy was successful. In this instance it is important to note that a discharge/termination plan may be completed without input from you as well as a final review of your treatment plan, but it will be made available to you when requested.

By signing this form you acknowledge:

1) That if I terminate prematurely then I give permission for my therapist to complete the discharge plan without me;
2) That if I terminate prematurely I give permission to my clinician to complete the final review of my treatment plan without me; and,
3) I will be provided a copy of both documents if I request them.

__________________ ____

Date Signature of Client

Afton Office • 389 Adams, P.O. Box 376, Wyoming 83110 • 307-885-9883
Evanston Office PO Box 2910, Wyoming 82930 • 307-789-4224
Kemmerer Office • 821 Sage Avenue, Wyoming 83101 • 307-877-4466
Pinedale Office • P.O. Box 856, Wyoming 82941 • 307-367-2111

HIGH COUNTRY BEHAVIORAL HEALTH
CLIENT HANDBOOK

Welcome to High Country Behavioral Health. This document contains important information about our professional services and company policies. It also contains summary information about the Health Information Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment and heath care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. Please read this information carefully and write down any questions that you may have so that you may have a discussion with your clinician to clarify your understanding. We encourage you to keep this document for future reference.

OFFICE HOURS

We are open from 8:00 a.m. until 5:00 p.m. daily except on certain holidays. There are evening hours and groups by appointment only. If you have special circumstances please make them known and we will attempt to accommodate your needs.
You are welcome to contact your clinician at any time by leaving a message on our confidential voice mail. Our messages are checked every day during office hours. If you leave a message for your clinician after 5:00 p.m., please take note that your clinician will not receive your message until the next business day.

FEES

You will be expected to make full payment at the time of service. We accept Wyoming Medicaid, health insurance, cash, personal checks and Visa/MasterCard. We also offer a sliding fee scale. Sliding fees are determined by income, and family size, and proof of household income is required. If you have any questions about your fee, please ask your clinician or the office manager. In extreme cases, and as a last resort, debt collection services will be utilized to pursue the collection of fees from responsible third parties and/or individual clients. Clients will be informed by mail before their accounts are turned over to collections. Accounts will be considered delinquent when a client has failed to make payments or payment arrangements for more than 60 days unless prior arrangements have been made with the primary clinician.

SERVICES

Our licensed clinicians will fully explain to you the process of any treatment you will receive and will establish with you the goals you want to address in your treatment. If for any reason you are uncomfortable with the clinician you are working with please share your concerns so the problem can be resolved or another member of the clinical staff can be made available to you. If we are unable to assist you with the needs you wish to address, we can assist you in finding those services in another location.

Services are offered to children, adolescents and adults. Depending on need clients may be seen individually or with other family members. Any services provided to a child under 18 will

require a parent or legal guardian's consent for treatment with appropriate signatures.

SERVICES OFFERED

Assessment and Evaluation
Individual Therapy
Family Therapy
Marital Therapy
Case Management
Community Based
Treatment
Substance Abuse Treatment
Intensive Substance Abuse Treatment
Consultation

Education
Women with Dependent Children
Prevention
Psychiatric Medication Management
Adults with Mental Illness
Emergency Services
Services for: Veterans,
Persons on Probation or Parole,
Pregnant Women,
Intravenous drug users.

ASSESSMENT

Our typical procedure is to conduct an assessment that may last from 1-3 sessions. During this time, both you and your initially assigned clinician can determine if they are the best person to provide the services that you need in order to meet your treatment goals. Typically a therapy session lasts approximately 50 minutes and sessions will be scheduled at a mutually agreed-upon time at intervals that best suit the needs of the work being done.

CANCELLATION & NO SHOW POLICY:

Clients who fail to attend their appointments will be charged a $25.00 NO-SHOW FEE and reschedule with their primary clinician. If this is a repeated problem or if clients would like a session sooner than the next available appointment they will be encouraged to access services during the next convenient WALK-IN CLINIC.
High Country Behavioral Health will also notify you in advance of any administrative problem that might result in your appointment being canceled or rescheduled; i.e. staff illness, emergencies, inclement weather, etc.

EMERGENCY SERVICES

Should an emergency arise during regularly scheduled business hours, please call the office. Your assigned clinician will assist you if he/she is available; otherwise an available clinical staff member will be assigned to the situation. At other times please call 911 or 885-3141 for Afton dispatch, 877-3971 for Kemmerer dispatch, 783-1000 for Evanston dispatch, and 367-4378 for Pinedale dispatch. The dispatcher will locate the on-call clinician who will then contact you.

REFERRAL

At times it may be necessary to work with other community resources to assist you in meeting your needs. We will make appropriate referrals to these resources. It will be your responsibility to follow through on these referrals.

REPORT AND RECORD KEEPING

Health information which we receive and/or create about you, personally, in this office, relating to your past, present, or future health, treatment, or payment for health care services, is "protected health information" under Federal law. Generally, our programs may not say to a person outside the program that you attend the program, disclose any information indentifying you or use or disclose any other protected health information except in limited circumstances as permitted by Federal law.

CONSULTATION WITH OTHER PROFESSIONALS

Other HCBH staff may be consulted regarding your treatment. If consultation with outside agencies is necessary, it will occur only after you sign a release of information (except in those circumstances as outlined in the Notice of Privacy Practice).

DISCHARGE/TRANSITION PLAN

When treatment goals and objectives have been met, you and your clinician will complete a discharge process which will include a transition plan for continuing care and follow-up.

FOLLOW-UP

Following your discharge from treatment, HCBH will contact you at some point to conduct a follow-up survey regarding your progress since discharge.

PSYCHIATRIC & MEDICATION MANAGEMENT SERVICES

These are services for the prescription of and/or monitoring of the effects of psychotropic medications. This service is offered through teleconference with an appropriately licensed prescriber. Please consult with your clinician to arrange this process.

COMMUNICABLE DISEASE CONTROL NOTIFICATION

It is important for you to know that individuals who use alcohol and other drugs are at a higher risk for communicable diseases, such as Hepatitis, HIV, STDs and Tuberculosis, then the general public. You are strongly encouraged to be tested at your Public Health Office.

YOUR TREATMENT RIGHTS

- In accordance with Wyoming statutes, persons served by mental-health centers have the right to impartial access to services. High Country Behavioral Health does not discriminate in the provision of services to individuals based on their inability to pay, race, color, sex, national origin, disability, religion, or sexual orientation. Services will not be denied if a client does not have the ability to pay or method of payment.
- You have the right to be guaranteed the protection of the confidentiality of your relationship with your mental health and substance abuse professional, except when laws or ethics dictate otherwise.
- Persons are served under the guidelines of informed consent. Persons served have an opportunity to be informed participants in their treatment decisions. It is generally accepted that complete informed consent includes a discussion of the following elements:

the nature of the diagnosis, reasonable alternatives to the proposed treatment or intervention, the relevant risks, benefits, and uncertainties related to each alternative, assessment of client understanding, the acceptance of the intervention/diagnosis by the client.

- You have the right to have your personal dignity and privacy recognized and respected in the provision of all services.
- You have the right to receive services without worry about abuse, financial or other exploitation, retaliation, humiliation, and neglect from staff.
- You have a right to an individual plan for your treatment which provides for the least restrictive care that may be expected to benefit you.
- You have the right to initiate a grievance and obtain a mechanism for requesting a review of the grievance.
- You have the right to access your treatment record. In some very limited circumstances, we may, as authorized by law, deny your request. You will be notified of a denial to any part or parts of your request.
- You have the right to access legal entities for appropriate representation.
- You have the right to access self-help and advocacy support services.
- You have the right to be notified under what conditions these rights may be restricted, including criteria for resolution and return to treatment.

CONFIDENTIALITY

In general, the confidentiality of all communication between a client and a licensed clinician is protected by law, and can only be released with your permission by signing our Authorization to Release Confidential Information. For Marriage and Family Therapists, The code of ethics is clear that treatment records cannot be released unless all the adults who participated in therapy sign such forms giving written permission for confidential information to be communicated.

In the case of a minor's right to confidentiality, HCBH will only release the record in response to a signed court order. An agreed-upon stipulation in a parenting plan or a proposed order does not qualify. This court-imposed requirement is designed to protect the minor's confidentiality and client/therapist relationship.

There are a number of exceptions to the general right to confidentiality. In most judicial proceedings, you have the right to prevent any information about your treatment from being shared. However, a judge may require your clinicians testimony if it is determined that the resolution of the issues before the court demands this testimony (e.g., child custody proceedings in which a parent's emotional condition is an important element.)

There are some situations, and laws, in which a clinician, or other staff member, is required or permitted to take actions to protect others from harm, even though that requires revealing some information about a client's treatment.

1. **Child Abuse Reporting**. If it is suspected that a child, an elderly person, or a person of disability is being abused or neglected, a report must be filed with the appropriate agency.
2. **Crimes on program premises or against program personnel**. If it is believed that a person is threatening serious bodily harm to another person, or threatens to damage the property of another, protective action is required which may include notifying law

enforcement with limited information concerning the circumstances of the incident and the client's status, name, address, and last known whereabouts.

3. **Medical Emergencies.** If someone threatens to harm him/herself, the clinician may be required to seek hospitalization, or contact family members or others who can help provide protection. Information may be disclosed to medical personnel who have a need for the information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.
4. **To Auditors & Evaluators.** This program may disclose protected health information to regulatory agencies, funders, third party payers, and peer review organizations that monitor programs to ensure that the program is complying with regulatory mandates and is properly accounting for and dispersing funds received.
5. **Authorizing Court Order**. This program may disclose your protected health information pursuant to an authorizing court order.
6. **Other Uses and Disclosure of Protected Health Information.** Any other conditions or circumstances relevant to Federal confidentiality rules (42-CFR Part 2) (45-CFR parts 160 & 164).

In every instance, all efforts will be made to fully discuss it with you before taking action.

Federal confidentiality rules (42-CFR Part 2) prevent the use of any information we have obtained to be used to criminally investigate or prosecute any alcohol or drug client. Disclosure of client identifying information is permitted if authorized by a court order, after application showing good cause.

MINORS

If you are under the age of eighteen, please be aware that the law does provide your parents with the right to examine your treatment records. If parents agree to limited access, they will be provided with general information about how your treatment is proceeding unless your clinician believes there is a high risk of you seriously harming yourself or another person, in which case they will be notified about such concerns. If the treatment is for drug dependency, parents may examine the records of children under age 12. A summary of your treatment may also be provided to your parents. Before such action is taken, it will be discussed with you, and all efforts will be made to resolve any objections you may have regarding what is to be discussed.

SUGGESTION, COMPLAINT, GRIEVANCE

If you have a suggestion, complaint, or grievance you may contact any employee who will assist you. If you wish to make a formal complaint or grievance because you believe that you are not being respectfully treated or for any other reason please ask for a grievance form. On the form you will be asked to do the following: write the dates of the events, times, the nature of your complaint or grievance, names of individual employees or staff involved, the names of any witnesses, action requested or relief sought and any other pertinent information.

This information will be given to the Executive Director who will contact all persons involved to gather information as necessary. The Director will inform you of the outcome of your complaint within 30 days. If you are not satisfied with the Director's decision, you may state in writing your dissatisfaction and your complaint will be scheduled for review during executive session of the

Board of Directors at their next board meeting.

You may also contact the Wyoming Department of Health – Behavioral Health Division at 6101 Yellowstone Road, Room 220, Cheyenne, Wyoming 82002-0480.

OUR ON-SITE POLICIES

Non-Smoking Policy - High Country Behavioral Health is a smoke-free environment. No smoking or smokeless tobacco use is allowed inside the building. Designated areas for smoking are located outside the building. Smoking is allowed in the designated areas and at least 25 feet from any entrance or window.

Drugs, Alcohol, and Medication Use Policy - Possession, use, sale, purchase, or distribution on any property or service location of HCBH, of any alcohol, illegal drugs, or illegally possessed drugs is strictly prohibited. Possession or administration of perscription medicaitons while participating in an outpatient service at HCBH is generally unnecessary and must be disclosed to clinical staff if it is being contemplated.

Firearms/Weapons Policy - Firearms or weapons are not permitted on Company property, or other occupied locations, including the parking lots. Any weapons brought on agency property will be reported to law enforcement.

Seclusion and Restraint Policy - Under **no** circumstance is physical punishment ever to be administered to persons served at High Country Behavioral Health. Briefly holding a person served, without undue force, for the purpose of comforting him or her to prevent self-injurious behavior or holding a persons hand or arm to safely guide him or her from one area to another is not a restraint. Separating individuals threatening to harm one another, without implementing restraints is not considered restraint.

Safety Policy - High Country Behavioral Health will comply with generally accepted standards governing health, sanitation, fire safety and with existing local inspection codes.
Your clinician will review all safety and emergency procedures with you during your initial visit. Located in each office are evacuation routes and locations of fire extinguishers. First aid kits are kept in each building and many employees are first aid and CPR certified.