NView Behavioral Health Clinic of Idaho of Idaho

Date: ☐☐/☐☐/☐☐

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ☐☐/☐☐/☐☐ Age: _____ Gender: ☐F ☐M

Address: _____ City: _____ State: _____ Zip: _____

Phone: (☐☐☐) ☐☐☐-☐☐☐☐ Alternate Phone: (☐☐☐) ☐☐☐-☐☐☐☐

Social Security # ☐☐☐-☐☐-☐☐☐☐

☐ Spouse / ☐ Guardian & phone #: _____

School & School's Phone #:_____

Emergency Contact Information

Who would you like us to contact in the event of an emergency? _____

Relationship: _____ Phone # _____

Your Care Team

Primary Care Physician: _____ Phone # _____

Psychiatrist/ Medication Management Provider: _____ Phone # _____

Other Provider: _____ Phone # _____

Other Provider: _____ Phone # _____

Current Medications

_____

_____

Employment Information (if participant is a minor, please use parent / guardian's information)

Employer: _____ Phone # _____

Spouse's Employer: _____ Phone # _____

Substance Abuse Information:

Date of Last Use: _____ Drug Used: _____

Frequency of Use:_____ Previous Attempts to Discontinue Use:_____

Insurance Information

Primary Insurance: _____ Phone # _____

Identification # _____ Group # _____

Subscriber: _____ Subscriber DOB: _____

Participant's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:
_____

Secondary Insurance: _____ Phone # _____

Identification # _____ Group # _____

Subscriber: _____ Subscriber DOB: _____

Participant's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:
_____

*** THIS SECTION MUST BE COMPLETED FOR SERVICES TO BEGIN ***

_____ Social Security # ☐☐☐-☐☐-☐☐☐☐

Printed Name of Person Responsible for Payment

_____

Signature of Person Responsible for Payment

Referral Information

Was participant referred to NView Behavioral Health Clinic of Idaho by another provider? ☐ Yes ☐ No

If so, whom? _____

Has participant had a complete history and physical in the last 12 months? ☐ Yes ☐ No

If so, where? _____

Has participant received case management / service coordination in the last 12 months? ☐ Yes ☐ No

If so, where? _____

Has participant received PSR / CBR (Community Based Rehabilitation) in the last 12 months? ☐ Yes ☐ No

If so, where? _____

Has participant received DD services in the last 12 months? ☐ Yes ☐No

If so, where? _____

Has participant been in foster care in the last 12 months? ☐ Yes ☐No ☐Currently

Does participant need an interpreter? ☐ Yes ☐No If so, what language? _____

Services Requested (or services I'd like to learn more about):

☐ Counseling / Therapy ☐ Groups ☐ Outpatient SUD ☐Intensive Outpatient SUD

☐ Case Management (formerly Service Coordination) provided by a contracted agency

Funding Source:

☐ Medicaid ☐ Self-Pay ☐ EAP ☐ Private Insurance

☐ Other: _____

Recipient's Rights Notification

The information contained in this form explains your rights and the process of filing a complaint if you feel your fights have been violated.

Your Rights As A Participant

- We will investigate your complaints.
- You are invited to make suggestions with regard to aspects of the services we provide.
- Your civil rights are protected by state & federal laws.
- You may request services from a provider at NView Behavioral Health Clinic of Idaho which includes Behavioral Health and SUD counseling. Your provider has training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will assist in locating more appropriate services to fulfill your needs.
- You have the right to take part in formulating your treatment plan (including goals, objectives, and crisis planning).
- You may refuse services offered to you and have the right to be informed of any potential consequences, such as violation of probation / parole, etc.
- With regard to medical and legal advice, you may discuss your treatment with your doctor and / or your attorney.
- HIPAA: Please see the accompanying Notice of Privacy Practices.

Your Rights to Receive Information

- We will provide you with information describing any potential risks of medications prescribed at NView Behavioral Health Clinic of Idaho Mental Health & Mediation.
- We will inform you of how much you will pay for services.
- You will be informed as to what behaviors or violations could lead to termination of services at this agency.
- We will inform you of any policy changes in writing.

Our Ethical Obligations

- We pride ourselves on serving the best interests of the individual needs of each participant to the best of our abilities.
- We will not discriminate against participants or professionals based on age, race, creed, disability, handicap, sexual preference, or other personal matters.
- We maintain an objective and professional relationship with each participant.
- We respect the rights and views of other mental health professionals.
- We will appropriately end services or refer participants to other programs when appropriate and applicable.
- We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of professional improvement.
- We will continually attain further education and training.
- We hold respect for various institutional and managerial policies, but will help improve such policies to ensure the best interest of the participant is served.
    - The right to impartial access to treatment and services, regardless of race, creed, color, religion, gender, national origin, age, or disability.
    - The right to a humane treatment environment that ensures protection from harm, and provides privacy to as great a degree as possible with regard to personal needs, and promotes respect and dignity for each individual.
    - The right to communication in a language and format understandable to the participant.
    - The right to be free from mental, physical, sexual and verbal abuse, neglect, and exploitation.
    - The right to receive services within the least restrictive environment possible.
    - The right to an individualized service plan, based on assessment of current needs.
    - The right to actively participate in planning for treatment and recovery support services.
    - The right to have access to information contained in one's record, unless access to particular identified items of information is specifically restricted for that individual participant for clear treatment reasons in the participant's treatment plan.
    - The right to confidentiality of records and the right to be informed of the conditions under which information can be disclosed without the individual's consent.
    - The right to refuse to take medication unless a court of law has determined the participant lacks capacity to make decisions about medications and is an imminent danger to self or others.
    - The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.
    - The right to refuse to participate in any research project without compromising access to program services.

- The right to exercise rights without reprisal in any form, including the ability to continue services with uncompromised access.
- The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense.
- The right to be informed in advance of the reason for discontinuance of service provision, and to be involved in planning for the consequences of that event.
- The right to receive an explanation of the reasons for denial of service.

Responsibilities of the Participant

- You are responsible for your financial obligations to the agency as outlined in the Financial Policy portion of this packet.
- You are responsible for following the policies of the agency.
- You are responsible for treating the staff and fellow participants in a respectful, appropriate manner in which their rights are not violated.
- You are responsible for providing accurate information about yourself.

PLEASE CONTACT THE CLINICAL DIRECTOR IF YOU FEEL YOUR RIGHTS HAVE BEEN VIOLATED.

_____

Participant Name (IF MINOR-Name of Parent/Legal Guardian)

_____ _____

Participant Signature (IF MNIOR-Parent/Legal Gaurdian) Date

Informed Consent & Agreement to Accept Services

Clinic Services include medication management and individual & family counseling and/or drug and alcohol services. Counseling is done 1:1 in the agency with a highly trained clinician and designed to help participants get to the root of their issues to begin the healing process.

I know I have a choice of Mental Health provider agencies for Behavioral Health and SUD programming/treatment. I have been provided with a list of agencies in the community. I have chosen NView Behavioral Health Clinic of Idaho. I have chosen NView Behavioral Health Clinic of Idaho to provide my services.

As a consumer, I know I have the right to change my providers at any time upon my request.

In signing this document, I acknowledge that I understand and consent to:

☐ Clinic Services ☐ Drug and Alcohol Services

_____

Participant Name (IF MINOR-Name of Parent/Legal Guardian)

_____ _____

Participant Signature (IF MNIOR-Parent/Legal Gaurdian) Date

Acknowledgement of Receipt of Privacy Notice & Practices

First Name: _____ Middle Initial: _____ Last Name: _____

Federal privacy laws (HIPAA) require us to ask you to sign this form to acknowledge that you have received a copy of our privacy notice.

This Privacy Notice explains how your health information may be used and disclosed and your rights regarding access and restrictions of your health information.

By federal law, our Privacy Notice should be provided to you on your first date of service with us.

If your first date of service with us was due to an emergency, we must give you our Privacy Notice and ask you to sign this acknowledgement of receipt of the Privacy Notice as soon as we can after the emergency is over.

TO BE COMPLETED AND SIGNED BY THE PARTICIPANT

☐ I have received a Privacy Notice from NView Behavioral Health Clinic of Idaho.

☐ I have been given the chance to discuss my concerns and questions about the privacy of my health information with a member of the staff at NView Behavioral Health Clinic of Idaho.

By signing this form, you acknowledge that we have given you a copy of our Privacy Notice.

_____
Participant Name (IF MINOR-Name of Parent/Legal Guardian)

_____ _____
Participant Signature (IF MNIOR-Parent/Legal Gaurdian) Date

_____ _____
Representative Signature Relationship Date

***FOR INTERNAL USE *** FOR INTERNAL USE ***

If the participant does not agree to sign this acknowledgement form, a staff member must answer the following questions:

Did the participant receive a copy of the Privacy Notice: ☐ Yes ☐ No

Why was the participant unable / unwilling to sign the acknowledgment form for receipt of the Privacy Notice?

_____
_____
_____

What efforts were made to try to obtain the patient's signature on the acknowledgment form?

_____
_____

_____ _____
Staff Member's Signature Date

FINANCIAL POLICY

The staff at NView Behavioral Health Clinic of Idaho (hereafter referred to as the Agency) is committed to providing caring and professional mental health care to all of our participants. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the Agency is designed to clarify the payment policies as determined by the management of the Agency.

The Person Responsible for Payment of the Account is required to sign this financial policy form. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the Agency will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amount s covered, and is not responsible for the collection of such payments. In some case insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our participants the usual and customary rates for the area. Participants are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 30 days. Payments not received after 90 days are subject to collections. A 1% per month interest rate is charged for accounts over 30 days.

If your account is sent to collections, it may be subject to a one-time fee of $20.00 and 12% annual interest.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amount s may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the Agency), this amount will be collected by the Agency until the deductible payment is verified to the Agency by the insurance company or third-party provider.

All insurance benefits will be assigned to this Agency (by insurance company or third-party provider) unless The Person Responsible for Payment of Account pays the entire balance each session. Participants are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan or payment at the time of service.

Payment methods include check or cash. In Idaho, dishonored checks, plus fees, must be paid within 15 days after the holder of such checks sends notice of dishonor or the following penalties may apply : "$100.00 or triple the amount of the check, whichever is greater." If you do not pay within the allotted time and further collection is warranted, you may also be held responsible for any collection fees and court costs.

Questions regarding the financial policies can be answered by the Clinical Director.
Members with Optum (Medicaid) Insurance will not be billed for Clinic Services

After 3 No-Show Cancellations without (24 hours) notice you will receive a final notice that services will be discontinued on the 3rd occurrence. This does not include life threatening emergencies

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Name of Participant: _____
Participant Name (IF MINOR-Name of Parent/Legal Guardian)

_____ _____

Participant Signature (IF MNIOR-Parent/Legal Gaurdian) FOR FINANCIAL POLICY Date

Person Responsible For Account: _____ Date: ___/___/___

Co-Responsible Party: _____ Date: ___/___/__

Consent for Treatment

Participant_____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at NView Behavioral Health Clinic of Idaho of Idaho, hereby referred to as the Agency. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Agency encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Non-Voluntary Discharge from Treatment: A participant may be terminated from the Agency non-voluntarily, if:
A) the participant exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the participant refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The participant will be notified of the non-voluntary discharge by letter. The participant may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

Participant Notice of Confidentiality: The confidentiality of patient records maintained by the Agency is protected by Federal and/or State law and regulations. Generally, the Agency may not say to a person outside the Agency that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the participant consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a participant's death, the spouse or parents of a deceased participant have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related participant records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor participants have the right to access the participant's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about participant, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Participant data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with NView Behavioral Health Clinic of Idaho.

_____ _____
Signature of Participant/Legal Guardian Date
(In a case where a participant is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

CONFIDENTIALITY STATEMENT

All Staff are obligated to respect your privacy. Your records and private conversations with our staff will be kept in strict confidence, even after you stop coming here for services. Others cannot see your records unless you agree in writing, or unless they law allows them to. However, because we are a state funded public agency, your name and basic identifying data are submitted to a computerized billing system for billing purposes. State auditors may also review your file in regard to billing and collection.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. You have my additional authorization to release information that may pertain to mental health care or treatment and/or to alcohol, drug, or substance abuse. I understand that the information disclosed pursuant to this Authorization may potentially be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws.

If an agency (e.g. probation, parole, etc.) has taken an action on my behalf which relies upon this release, I understand that I will abide by the stipulations of that action. I also understand that I may revoke this consent in writing at any time, except to the extent that it has been relied upon by the Agency, by contacting the Agency at the address above. This consent automatically expires 6 months after my termination from the Agency program. I release the Agency from any or all responsibility and liability concerning the release of information I have consented to the above. I agree that a copy of this release may serve as the original.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

We are required to report a life endangering situation if it comes to our attention, and if ordered to do so under law, we are obligated by law to report any child sexual abuse, physical abuse, or neglect that is disclosed. We must warn others about threats you may make toward them. For additional detail on your privacy rights under HIPAA, please see the accompanying Notice of Privacy Practices.

I have read and understand the NView Behavioral Health Clinic of Idaho of Idaho's Policy on confidentiality.

_____

Participant Name (IF MINOR-Name of Parent/Legal Guardian)

_____ _____

Participant Signature (IF MNIOR-Parent/Legal Gaurdian) Date