PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

Patient Name: _____ Date of Birth: _____
First M Last

Social Security #: _____-_____-_____ Gender: M F Marital Status: S M W D Race: _____

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

Home Ph #: _____ Cell #: _____ E-mail: _____

Employer: _____ Work Phone: _____

Preferred Contact Method: Home / Cell / Work Message OK: Home / Cell / Work Appt. Reminders by text? □Yes □No

Referring Physician/Facility/Program:_____

Primary Care Physician: _____

Preferred Pharmacy: _____ Location: _____

Preferred Lab: Labcorp Quest Diagnostics CPL

Living Situation: □Independent □Spouse □Child □Adult Residential Facility □Assisted Living □Other: _____

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD TO COPY)

PRIMARY: ROI MUST BE FILLED OUT

Insurance Co.: _____ Policy Holder/Relationship: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

SECONDARY: ROI MUST BE FILLED OUT

Insurance Co.: _____ Policy Holder/Relationship: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

SPOUSE

Name: _____ Date of Birth: _____

EMERGENCY CONTACT: ROI MUST BE FILLED OUT

Name/Relationship **Phone**

_____

Check any of the following that you have in place: □Advanced Directive (Medical and/or Psychiatric) □DNR □POA □Living Will □Healthcare Proxy:_____ (please provide paperwork for any checked boxes)

Power of Attorney: _____ Relationship: _____ Phone Number: _____

Patient Signature _____ Date ___/___/___

Guardian Signature if applicable _____ Date ___/___/___

Patient's Name:_____ DOB _____DATE_____

CONSENTS/POLICIES

1. **Consent to Evaluate/Treat:** I voluntarily consent to participate in a mental health evaluation and/or medical treatment by staff from WC Health. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the therapeutic services
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment.
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a licensed clinician, therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Nevada Law for Licensed Clinical Social Workers, Licensed Social Workers, Marriage and Family Therapist(I)s and Licensed Clinical Professional Counselors, Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, and Physician's Assistant.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with clinical interviews, psychotherapy, psychiatric rehabilitation, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including copayments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at WC Health, and I consent to disclosure for use by WC Health staff for the purpose of continuity of my care. Per Nevada and federal mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible child abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician. I understand that if my services are court ordered your treatment services may be suspended if consent is withdrawn as it will no longer permit WC Health to provide effective treatment and treatment continuity.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

7. **Notice of Privacy Practices:** I hereby acknowledge that I have received and have been given an opportunity to read a copy of WC Health LLC, Privacy Practices. My signature of this document on the last page indicates that I give consent for WC Health to use and disclose my health information as described in the Notice of Privacy Practices. understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at WC Health. 702-291-7121

8. **Telehealth Services:** Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.

9. Providers may include primary care clinicians, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:
    - Patient Medical Records & Medical Images
    - Live two-way audio and video
    - Output data from medical devices, sound, and video files

    Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Responsibility for patient care remains with the patient's local clinician, as does the patient's medical record.
    Expected Benefits:
    Improved access to medical care by enabling a patient to remain in a local health care setting. More efficient medical evaluation and management. Obtaining the expertise of a specialist.
    Possible Risks:
    As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to, the following:

    - In rare cases, the consultant may judge that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient.
    - Delays in medical evaluation and treatment could occur due to limitations or failures of the equipment.
    - In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

    By signing this form, I indicate that I understand the following:

    - I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no patient identifiable information obtained in the use of telemedicine will be disclosed to researchers or other entities without my consent.
    - I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
    - I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
    - I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
    - I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners involved in my care who may be located in other areas, including out of state.
    - I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
    - I understand that individuals other than my health care provider and consulting health care provider may be present and that they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence.

I have read and understand the information provided above regarding telemedicine, have discussed it with my clinician or such assistants as may be designated the clinician. My signature below indicates that I authorize WC Health Medical and Behavioral Health Services to use telemedicine in the course of my diagnosis and treatment.

10. **Grievances**: WC Health is committed to providing quality client care and promotes patient and family satisfaction. To promote continuous high quality care, WC Health will process grievances and feedback in a consistent and timely manner.

PROCEDURE:

- WC Health will ensure that Grievance and Feedback forms are readily available to all patients of WC Health. They will be located in facility lobbies, as well as electronically and from any staff member upon request.
- Completed forms may be submitted to any staff member, left in a secured dropbox in any WC Health office, and through the process available on the WC Health website.
- WC Health recognizes that feedback is often given in the form of other electronic platforms and social media, such as Google, Yelp and Facebook. In these cases, the Marketing Department will gather all feedback to compile in an electronic file to be submitted with others received.
- All completed forms are to be collected by the supervisor of each program by the end of the business day. Any electronic feedback will be given to the supervisor of the program or services that is the target of the complaint. The Marketing Department will forward them, whenever possible in real time or by the end of the business day. In this way anything that can be addressed while the person is in the program area, will be managed directly by that person or their designee.
- The Supervisors will ensure that all feedback/grievances received are addressed in a timely manner. Additionally, how they are being addressed is also to be explained in the response area on the form. They are then to be sent to the Quality Assurance Department within 24 hours.
- The Quality Assurance Department will ensure each issue is fully addressed and documented for tracking/trending purposes. The outcome(s) related to a complaint may or may not be disclosed to the grieving party. This should be shared with the complainant if they request to be contacted. Personnel issues or actions will not be shared with the person filing the grievance.
- In the event a grievant is dissatisfied with WC Health's resolution of their grievance, the issue(s) in dispute may be revisited through the appeal process.
- The grievant may file an appeal within 60 days of the receipt of the treatment program's decision using the Grievance/Feedback form.
- This appeal will be reviewed and decided by appropriate staff that is separate from the staff that brought forth the first decision.
- WC Health will respond to any appeal within 5 business days of receipt.
- Clients shall not be subject to any discrimination, penalty, sanction, or restriction for filing a grievance.

11. <u>Client Rights</u>: The following applies to all WC Health clients:

- If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.
- You have the right to be provided treatment appropriate to your needs.
- If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.
- You have the right to be informed of all program services, which may be of benefit to your treatment.
- You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.

- You have the right to be informed of the name of the person responsible for the coordination of your treatment and of the professional qualifications of staff involved with your treatment.
- You have the right to be informed of our diagnosis, treatment plan and prognosis.
- You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.
- You have the right to be informed if the facility proposes to perform experiments that affect your own treatment , and the right to refuse to participate in such experiments.
- You have the right to examine your bill for treatment and to receive an explanation for that bill.
- You have the right to be informed of the program's rules for your conduct at the facility.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal. You have the right to receive respectful and considerate care.
- You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.
- You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so. You have the right to safe, healthful and comfortable accommodations.
- You have the right to confidential treatment. This means that other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that you are a patient.
- Waiver of any civil or other right protected by law cannot be required as a condition of program services.
- You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.
- You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.
- You have the right to grieve actions and decisions of facility staff, which you believe, are inappropriate, including but not limited to actions and decisions, which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retaliation or other adverse consequences as the product of filing a grievance.
- You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency-4126 Technology Way-2nd floor, Carson City, NV 89706: Phone-775-684-4190
- You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

12. **Client Responsibilities:** You will be expected within the limits of your abilities to assume a share of the responsibility for your health care. Your responsibilities include being on time for scheduled events, or notify the appropriate person if you will be late or need to cancel an appointment, participate in the formulation of your treatment plan and be responsible for working on meeting your goals, treat members of your treatment team and other clients with respect, and meet your financial and required documentation of records in a timely manner. All patients enrolled at the clinic are asked to be responsible for the following:

    - Be on time for scheduled appointments.

- Notify the clinic 48 hours in advance if unable to keep a scheduled appointment.
- Participate in the formulation of the treatment plan.
- Treat the clinic staff, property, and other clients in the clinic with respect.
- Make payment of the determined fee in a timely manner.
- Submit the immunization record and physical exam that is no more than every 12 months.
- Provide accurate and honest information to care providers and other staff.

13. **Random Drug Testing:** Please be advised that all patients may be subject to a random drug test at your provider's request. When giving a urine sample we request that you wash your hands before entering the restroom and leave all belongings on the counter and do not flush the toilet. Your signature below indicates that you understand that you may be requested to adhere to a drug test at your provider's request.

14. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) of 1996:** THIS NOTICE DESCRIBES HOW MEDICAL, DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Acts of 1996 (HIPAA), 42 U.S.C 1320d et seq., 45 C.F.R Parts 160 & 164, and the Confidentiality Law, 42 U.S.C 290dd-2, 42 C.F.R Part 2. Under these laws, WC Health may not say to a person outside WC Health that attends the program nor may WC Health disclose any information identifying you as a mental health, alcohol or drug abuse client or disclose any other protected information except as permitted by federal law.

WC Health must obtain your written consent before it can disclose information about you for payment purposes. For example, WC Health must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before WCI Health can share information for treatment purposes or for health care operations. However, federal law enforcement permits WC Health to disclose with any qualified services organization/business associate pursuant to an agreement with qualified services organization/business associates

1. For research audit or evaluations
2. To report a crime committed on WC Health premises or against WCH personnel
3. To medical personnel in a medical emergency
4. To appropriate authorities to report suspected child abuse or neglect as allowed by a court order.

For example, WC Health can disclose information without your consent to obtain legal or financial services or to another medical facility to provide healthcare to you as long as there is a qualified service organization/business associate agreement in place. Before WC Health can use or disclose any information about your health which is not described above, it must obtain your specific written consent allowing them to make the disclosure. You may revoke any such written consent in writing by filling out a Revocation Form (can be obtained in any WC Health Office or staff) and send to:

WC Health

ATTN: Medical Records 5412 Boulder Highway Las Vegas, NV 89122

OR
medicalrecords@wc-health.com

The Revocation form must be received by the medical records office to become valid.

Your Rights: Under HIPAA you may have the right to request restrictions on certain uses and disclosures of your health information. WC Health is not required to agree to any restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

The EHR Software makes it a priority to keep this piece of software updated with the most recent available security options, so it will integrate easily into a HIPAA-compliant practice and will protect our customers with at least the official HIPAA (Health Insurance Portability & Accountability Act) regulations.

WC Health:

- Is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's Legal duties and privacy practices with respect to your PHI
- Under the Privacy Rule, it may be required by other laws to grant greater access or maintain greater restrictions on the use of, or release of your PHI than that which is provided for under federal HIPAA laws.
- Is required to abide by the terms of the Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and make new Privacy Notice provisions effective for all of your PHI that it maintains if needed
- Will distribute any revised Privacy Notice to you prior to implementation
- Will not retaliate against you for filing a complaint Patient Communications: Health Insurance Privacy Act 1996 USA, requires to inform you of the following government stipulations in order for us to contact you with educational and promotional items in the future via e-mail, U.S. mail, telephone, and/or prerecorded messages. We will not share, sell, or use your personal contact information for spam messages.

WC Health set up their User accounts for the EHR databases, requiring Users to log in with a password. The User is to exit or log out of any medical information when the information is no longer being used, or as soon as the default timeout is reached. When using this medical information for registration in front of patients, the User is to use the "Privacy" feature, to hide PHI (Personal Health Information) for other patients otherwise visible in the search screen. Standard operating procedures (SOPs) have been developed and are in use, requiring written documentation of the export of any patient medical information, or other database information. Users may only take a stored copy of any database information outside on a portable computer or other portable media if such export is recorded in writing. After signing out of with any portable device or transport medium, the information is to be erased when the need for the information is completed. If possible, this information is only to be taken outside in encrypted format. Only specific technicians may have occasional access to hardware and software. **The HIPAA Privacy Rule** requires a practice to have a signed Business Associate Contract before granting such access. The technicians are trained regarding HIPAA regulations, and limit the use and disclosure of customer data to the minimum necessary.

WC Health is a 42 C.F.R., Part 2 entity. Part 2 protects “records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.”

15. **<u>WC Health Discharge Policy:</u>** Immediate agency discharge of the patient may occur upon the discretion of the management team for any of the following behaviors which may compromise the outcome of mental health treatment and/or the safety of staff or patients (this list is not all-inclusive):

    - Tampering with prescriptions
    - Behaviors or information that suggest medication is being sought for the purpose of illegal use or distribution instead of treatment use as directed or medication is being willfully misused for another purpose
    - Threatening behaviors towards staff and other patients
    - Property destruction
    - Theft of property
    - Physically or verbally assaultive behaviors towards staff or other patients
    - Verbal abuse or threats to staff or other patients
    - Concurrent or excessive no shows (typically three consecutive no shows for any agency program)
    - Failure to comply with individualized contract and treatment plan
    - Inappropriate sexualized behavior towards staff or other patients
    - Carrying a weapon or using any object as a weapon, or carrying drugs, or drug paraphernalia on WC Health property
    - Consecutive rescheduling or no shows to physician, therapist, and/or a combination of appointments.
    - Other behaviors deemed grossly negligent, threatening, harmful or detrimental to staff or other patients.

16. **<u>Advance Directive For Mental Health Care:</u>** It is the Policy of WC Health to encourage patient self determination. Patients will be encouraged and assisted to be active participants in the decision making process involving their care through education and assistance as needed. Patients will be encouraged to communicate their desires in regard to Psychiatric Advance Directives to their care team to ensure the care team is informed of the patient's wishes should the patient become unable to make decisions concerning their mental health. WC Health can provide you with an information based packet but we cannot provide you with legal advice.

17. **<u>MEDICARE PATIENTS ONLY: Chronic Care Management (CCM) Treatment Consent:</u>** As a patient with two or more chronic conditions such as long term (chronic) heart, lung, kidney disease, infectious disease, depression, psychosis, or anxiety, you may benefit from a program that WC Health offers all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care.

    We can help you coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

    Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

    ***You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
- We will bill Medicare for this chronic care management for you once a month. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment.
- Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

- A Comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
- Discontinue this service at any time for any reason.

Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.

We believe that to achieve this goal there must be a partnership between the patient and their medical provider. By remaining involved in the decisions regarding your health, health care and lifestyle, we can develop a stronger relationship with you.

18. **Infection Prevention and Control:** WC Health has an infection prevention and control plan to reduce risk and spread of infection. WC Health Leaders are to report infection surveillance, prevention, and control information to organization staff consistent with their responsibilities for infection prevention and control activities. Reporting of this information about the occurrence of infections to local, state, and federal public health authorities is to be done in accordance with law and regulation. When patients or staff have or are suspected of having an infectious disease that puts others at risk, leaders of WC Health reserve the right to refer the suspected individuals for assessment and potential testing, prophylaxis/treatment, or counseling prior to their return to clinic.

    My signature at the bottom of this document indicates that I am aware that if I, or any individual usually brought to WC Health, suspect/s or confirm/s I/they have a contact communicable, airborne communicable, or liquid communicable condition (for example: head lice or bed bugs), I will notify the relevant staff of the reason for not attending Clinic, and I will not come to, or bring them to WC Health.

WC HEALTH CONSENT ACKNOWLEDGEMENT AND SIGNATURES

** Name: _____ ** Date of Birth:_____

I have received information on the following policies which I can obtain a copy of from staff and/or a WC Health Office:

1. **Consent to Evaluate/Treat**
2. **Benefits to Evaluation/Treatment**
3. **Charges**
4. **Confidentiality, Harm, and Inquiry**
5. **Right to Withdraw Consent**
6. **Expiration of Consent**
7. **Notice of Privacy Practices**
8. **Telehealth Services**
9. **Grievances**
10. **Client Rights**
11. **Client Responsibilities**
12. **Random Drug Testing**
13. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) of 1996**
14. **WC Health Discharge Policy**
15. **Advance Directive For Mental Health Care**
16. **MEDICARE PATIENTS ONLY: Chronic Care Management (CCM) Treatment Consent**
17. **Infection Prevention and Control**

Check and Initial the section that applies:

** ____ I, AGREE to participate in the Chronic Care Management program. INITIALS: ____ ** Contact Number_____

** ____ I do not agree to participate in the Chronic Care Management program. INITIALS: ____ **

INITIAL the box for the appropriate statement:

_____ * I have an Advance Directive. (Please send a copy of your Advance Directive to WC Health).

_____ * **I do not have an Advance Directive**, and I would like to receive an information packet regarding Advance Directives.

_____ * **I do not have an Advance Directive**, and I would NOT like to receive an information packet regarding Advance Directives.

SIGNATURES FOR ENTIRE CONSENT FOR TREATMENT DOCUMENT:

My signature below shows that I have read, understood, and accept all of the above terms of consent for treatment/policies and I understand that I have the right to select a qualified provider of my choosing. I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

I understand this consent is valid for one year and I have the right to withdraw consent at any time and for any reason.

I further understand I will be asked for consent and signature annually to continue care.

** Patient Signature: ** _____ ** Date: _____

** Parent or Guardian Signature (for all under 18 + as applicable): ** _____

** Printed name of Guardian or Parent: ** _____

Release of Information: General PHI

This document allows WC Health, or its authorized representatives to use and disclose Protected Health Information (PHI) as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal laws concerning the privacy of PHI (45cfr164.50842 C.F.R. Part 2). Please send all requested documents to Fax # **702-947-6335** or email: medicalrecords@mywellcareservices.com.

PATIENT NAME:_____ DOB: ____/_____/_____ SSN: _____

ADDRESS:_____

I authorize WC Health to **Release** Records to:

_____

_____

_____

I authorize WC Health to **Obtain** Records From:

_____

_____

_____

Purpose of disclosure: _____

Expiration of disclosure (1 year from date if left blank): _____ Disclose by: ☐Email ☐Fax☐Phone☐Person

Please Initial each type of information to be disclosed:

____All Medical Records
____All Progress Notes
____Medication Records
____Attendance Record
____Psychiatric Progress Notes
____Therapy Progress Notes
____Medical Progress Notes
____Medical Assessment
____Billing for Services
____Diagnostic Reports (Labs, EEG, X-Ray, etc.)
____Discharge Summary
____Psychiatric Assessment
____Other:_____

If not ALL records, then Records from ____/____/____ to ____/____/____

Notice of rights and other information:

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I may refuse to sign this authorization. I may cancel this authorization at any time. I must give written notice of such cancellation. I can obtain a revocation form from any WC Health staff, WC Health Office or by emailing medicalrecords@wc-health.com. The completed form must be sent to medicalrecords@wc-health.com to become validated. Cancellation of this authorization will not apply to information disclosed prior to the date of cancellation. I have a right to receive a copy of this authorization and one will be furnished upon my request. I have a right to receive a copy of the health information I am asking to disclose. I acknowledge that I have read this authorization, that the terms have been explained to me, that I understand all of the terms and I am competent to sign this authorization for myself or that I am authorized as a parent, guardian or legal representative to sign for the patient named above. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Patient/Parent/Guardian/Legal Representative Signature Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Release of Information: Insurance

This document allows WC Health, or its authorized representatives to use and disclose Protected Health Information (PHI) as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal laws concerning the privacy of PHI (45cfr164.508 and 42 C.F.R. Part 2). Please send all requested documents to Fax # **702-947-6335,** or email: medicalrecords@mywellcareservices.com.

PATIENT NAME:_____ DOB: _____ SSN: _____

ADDRESS:_____

I authorize WC Health to **Release** Records to:

_____

_____

_____

I authorize WC Health to **Obtain** Records From:

_____

_____

_____

The purpose of this disclosure is to exchange the information initialed below to promote coordination of care.

Expiration of disclosure (1 year from date if left blank): _____ Disclose by: ☐Email ☐Fax☐Phone☐Person

Please Initial each type of information to be disclosed:

____All Medical Records
____All Progress Notes
____Medication Records
____Attendance Record
____Psychiatric Progress Notes
____Therapy Progress Notes
____Medical Progress Notes
____Medical Assessment
____Billing for Services
____Diagnostic Reports (Labs, EEG, X-Ray, etc.)
____Discharge Summary
____Psychiatric Assessment
____Other:_____

If not ALL records, then Records from ____/____/____ to ____/____/____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I may refuse to sign this authorization. I may cancel this authorization at any time. I must give written notice of such cancellation. I can obtain a revocation form from any WC Health staff, WC Health Office or by emailing medicalrecords@wc-health.com. The completed form must be sent to medicalrecords@wc-health.com to become validated. Cancellation of this authorization will not apply to information disclosed prior to the date of cancellation. I have a right to receive a copy of this authorization and one will be furnished upon my request. I acknowledge that I have read this authorization, that the terms have been explained to me, that I understand all of the terms and I am competent to sign this authorization for myself or that I am authorized as a parent, guardian or legal representative to sign for the patient named above. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Patient/Parent/Guardian/Legal Representative Signature Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

ELECTRONIC COMMUNICATION CONSENT: ATTACHMENT

Electronic platforms used for healthcare communication include email, webmail, voicemail, open text messaging, encrypted text messaging, file transfer apps and online “portals.” Devices for e-Communication include computers, tablets and smartphones. Files may also be shared on CD/DVDs and flash/USB drives.

Advantages of Electronic Communication

- A convenient and effective way of connecting; many doctors and patients use it regularly
- Allows many questions and issues to be handled without a phone call or visit
- Messages can be sent and received without both parties needing to be online in real-time
- Messages can be saved, copied and forwarded; there is a record of what was sent
- Many systems are encrypted to protect privacy
- Many systems allow attachments, such as photographs or audio recordings

Disadvantages of Electronic Communication

- Connections can fail; messages can be lost or sent to the wrong recipient; privacy breaches
- There may be no way to know if a message was received
- Typing mistakes; auto-correction errors
- If the receiving party is busy or their device is turned off, messages will not be seen promptly
- Criminals can send false messages or impersonate a patient or a provider
- There is no opportunity to clarify misunderstandings in real-time
- Messages sent by mistake can’t be erased or retracted
- Messages can contain malware or viruses that can damage devices or steal information
- Some medical questions and issues can’t be handled through electronic messaging

Access: WC Health communicates electronically with patients through the information listed by the patient below. Please list the contact information you would like to use for this purpose. WC Health staff can only use the information listed below for electronic communication so if anything changes, please fill out a new form. Anything left blank in the table below will be considered an "opt-out" option.

Phone and Voicemail (provide phone #)	
Website/Patient Portal (provide email)	
WC Health Email (provide email)	
Provider Email (provide email)	
Text Messaging (SMS) number (provide phone #)	
Telemedicine access (provide email)	

Uses: **Some** departments of WC Health accept electronic messages for the following purposes (please check with the providers you work with to confirm that electronic messages will be accepted by WC Health from you, as the patient. If it is not, the electronic communication will only flow from WC Health to the patient):

- General messages like making or changing appointments, billing issues, or other questions that can be answered by an appropriate staff person.
- Appointment cancellation.
- Prescription renewals (existing prescriptions).
- Medical questions. Some – but not all –medical questions can be handled by email. Discuss with your provider whether electronic communication is appropriate for you.
- Telemedicine options: Separate Policy can be provided on request

Emergencies: DO NOT USE ELECTRONIC COMMUNICATIONS FOR EMERGENCIES. CALL 911!
Part of the record: Messages with important content will be saved as part of your medical record.
Security: Take care when sending or reading messages that your own device is secure and private.
Availability: If you ask us to communicate electronically with you, we will assume that you check your messages at reasonable intervals. We can't guarantee that we will respond to your messages and we understand you can't guarantee that you will respond to ours. For important issues, telephone is best!
Sensitive medical information: Because electronic messages can't be guaranteed 100% secure, please don't put sensitive matters in messages without considering this. You have the right to ask us to use either encrypted or unencrypted email for your correspondence with us. However, unencrypted email has a higher risk of being intercepted and your private information obtained by an unauthorized party.
Opt out: Please let us know if you do not wish to receive electronic communications by specifying below. If you are receiving electronic communications and wish to stop receiving them
Changes: If your email address or phone number changes, you need to fill out a new form, which can be obtained on the portal or through any WC Health office.
Non-essential uses: We will only use your email address or phone number for important communications related to WC Health. We will not give your email address or phone number to anyone who is not authorized.
Mistakes: Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. Delete any messages that are not intended for you.
Breach Notification: Please notify us immediately if you become aware of a possible privacy or security event that affects your devices.
Other risks: In addition to those above, electronic communication can have other risks and disadvantages that might cause inconvenience or harm. Everyone using electronic communications needs to use good judgment about these valuable technologies and must remember that there are alternatives that would be better for some situations.

Acknowledgment and Agreement

I acknowledge that I have read this form. I understand that electronic (online) communication has risks, including possible risks not mentioned above as well as others. I agree to abide by the policies described above. I agree to use reasonable judgment with regard to any messages I send or receive. I do not have any unanswered questions about what this Agreement covers. I understand that I can change my choices at any time.

By checking the boxes below:

☐I confirm that I control the privacy of the email address provided above.
☐I confirm that I control the privacy of the phone numbers listed above.
☐I confirm that I control the privacy of the telemedicine environment and do consent to telemedicine treatment.

Patient/Representative Signature	Date:

RELEASE OF INFORMATION: EMERGENCY CONTACT

EMERGENCY: A serious, unexpected, and often dangerous situation requiring immediate action

Client Name:_____Date of Birth: _____/_____/_____

(D&A, MH, or HIV-related information cannot be used/disclosed in reliance on this form. D&A and HIV-related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.)

I authorize WC Health to disclose my protected health information to the following person or entity (name/agency/relationship/phone number) for the sole purpose of **EMERGENCY CONTACT:**

_____

Please **initial** each topic below that WC Health can disclose to your Emergency Contact listed above:

_____ Location of client

_____ Nature of the emergency

_____ Notification of "against facility advice" discharge from residential program (enter N/A if this does not apply)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R.,Part 2, and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.
I understand that I have no obligation whatsoever to disclose any information from my patient record and I understand that I may revoke this consent at any time by notifying WC Health in writing. I can obtain a revocation form from any WC Health staff, WC Health Office or by emailing medicalrecords@wc-health.com. The completed form must be sent to medicalrecords@wc-health.com to become validated.

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identities a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see section 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at sections 2.12(c)(5) and 2.65.

This consent shall expire: _____/_____/____

If a date of expiration is not filled in above, this release of information will expire one year from the date this document was signed by the client/representative, upon discharge or upon revocation from the client.

Client Signature:_____ Date:_____/_____/____

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. Benzodiazepines, Hypnotics (Non-Benzodiazepines), and Stimulants) are very useful for controlling both acute and chronic **Anxiety, insomnia and ADD/ADHD** respectively. They all have a high potential for misuse and are, therefore, closely controlled/monitored by local, state, and federal governments. They are intended to relieve symptoms of the disorders stated above, thus improving quality of life, function and/or ability to work. Because my provider is prescribing controlled substance medications to help manage my symptoms in regards to my diagnosis, I agree to the following conditions.

TREATMENT GOALS

I understand that the main treatment goal is to reduce my symptoms to a manageable level and improve the quality of my life. In consideration of this goal, and because of the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. In addition to healthy habits, I will also attend psychotherapy as recommended by my provider. I must also comply with the treatment plan as prescribed by my provider.

PATIENTS' RESPONSIBILITY (Please **initial** next to each responsibility)

_____I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it will not be replaced.

_____ I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical/Psychiatric care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.

_____ I will use only one pharmacy for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.

____ I know that telephone refills are not allowed. **Calls or faxes from pharmacies to refill medications will not be authorized.**

____ I agree to random PILL COUNT to monitor medication usage. I understand that if the provider feels that I am at risk for psychological or physical dependence (addiction); my medications may be tapered off within 7 days. These will be performed during regular office hours. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for discontinuation of prescribed controlled medication. Patients who fail to show for random pill counts will be immediately terminated from the practice.

____ I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State while taking the prescribed medications.

____ I agree to undergo **random urine drug testing within 24 hours of office visit** at the discretion of the provider. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for medication taper to completion.

____ I will not request or accept same or similar form of controlled medications from any other physician while receiving treatment from this office. **I will not give, share or sell my medications to any other person.**

____I will turn in ALL medication prescriptions within 2 weeks after receiving them. If after 2 weeks the prescription expires, I will NOT receive new scripts. I will have to wait until the following month to received new prescriptions.

REFILLS OF MEDICATIONS

____Will be made only during regular office hours Monday through Friday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays. No telephone Refills to pharmacy.

____Will not be made if I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid theft.

____Will not be made as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 24 hour in advance to schedule an appointment for refills.

RISKS OF THE CHRONIC BENZODIAZIPINE USE

I understand that the long-term advantages and disadvantages of chronic Benzodiazepine use have yet to be scientifically determined. My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of

controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate. I am aware that tolerance to controlled medications means that I may require more medicine to get the same amount of symptoms relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to medications may force my doctor to choose another form of treatment.

RISKS OF THE CHRONIC STIMULANT USE

I understand that the long-term advantages and disadvantages of chronic Stimulant use have yet to be scientifically determined. But research finding suggests the following:

____ cardiovascular complications may appear earlier in older adults receiving maintenance amphetamine treatment. Because the way amphetamines work in the body differ between children and adults, evaluation of the potential for adverse effects of chronic treatment of adults is essential and warrants **YEARLY EKG TESTING**.

____ Amphetamines long-term use may pose a risk on the growth of children due to reduced caloric intake in view of the decrease in appetite associated with these drugs.

____Although most adult patients also use amphetamines effectively and safely, occasional case reports indicate that prescription use can produce marked psychological adverse events, including stimulant-induced psychosis and Mania.

RISKS OF THE CHRONIC HYPNOTIC USE

I understand that disadvantages of chronic hypnotic use have been scientifically determined. And the research finding suggests the following:

____Chronic hypnotic use is strongly associated with insomnia, poor function, and poor quality of life.

____ Chronic use of hypnotics may create sleep and performance problems, memory disturbance, driving accidents, and falls.

____There is no persuasive evidence that long-term use of hypnotics produces any benefit. Rather, the risks of chronic hypnotic use outweigh the benefits, which is why I will be prescribed hypnotics temporarily.

RISKS OF CONCOMITANT USE OF CONTROLLED SUBSTANCES

The concurrent use of opioids (Morphine, Oxycodone, Percocet, Tramadol, Hydrocodone, Dilaudid etc.), benzodiazepines (Xanax, Ativan, Clonazepam, Diazepam), Hypnotic (Ambien,

Temazepam, Halcion, Lunesta, etc.), alcohol, marijuana and other illicit drugs poses a higher risk of adverse events, overdose, and even death. To improve patient outcomes, ongoing screening for unusual behavior, monitoring of treatment compliance, documentation of medical necessity, and the adjustment of treatment to clinical changes are essential.

(FEMALE PATIENTS ONLY)

____I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

ACKNOWLEDGEMENT OF INFORMATION

I have been fully informed by my provider regarding the potential for psychological and physical dependence (addiction) of controlled substance medications and risk of chronic use of these medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under my provider's supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are used inappropriately.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice, I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. I am responsible for any withdrawal syndrome that may occur due to my misuse of the narcotic medications and/or termination of my care. I have read this contract and the same has been explained to me by my provider and the office staff. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Date_____ Patient_____

☐ Copy given to pt. ☐ Pt refused copy. Date _____ by _____