Anchorage Community Mental Health Services, Inc.
Fairbanks Community Mental Health Services, LLC.

CONSENT FOR SERVICES

Name of Client: _____ **Client #** _____

I, _____ (or _____)
Name of Client — Authorized representative acting on behalf of client

Request and voluntarily consent to receive mental health services from ACMHS/FCMHS (Organization). and its mental health staff. Such care may include routine diagnostic procedures and/or related services that the mental health staff may recommend as medically necessary. No guarantees have been made to me by the Organization as to the result of services or evaluation.

I understand that as part of my healthcare, this Organization originates and maintains health records that are used for Treatment, Payment and Health Care Operations.

MINOR CLIENTS ONLY: Are you the parent or guardian to the minor client? YES ☐ NO ☐

If "YES" to above, please provide **Photo ID to reception.**

_____ _____
SIGNATURE OF CLIENT — DATE

_____ _____
WITNESS — DATE

_____ _____
SIGNATURE OF **RELATIVE/ GUARDIAN** or **AUTHORIZED REPRESENTATIVE** — DATE

If you are signing as the caregiver for the minor client: I acknowledge I am signing as the caregiver for this minor. I attest that the parent/legal guardian is not available to sign for needed medical services at the Organization despite attempts to engage the relative or legal guardian.

_____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE — DATE

Printed Name and Relationship to Client: _____

STAFF only: Document(s) obtained (circle one): Legal Documentation of Guardianship; Unable to reach Guardian; Unable to produce documentation

Staff Completed:
Client Name:
Client ID:

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Client Profile

1. ***Name (First and Last):*** _____
2. ***Maiden Name:*** _____
3. Alternate/ Other Names you are known by: _____
4. ***Client Gender (circle response):*** Male Female
   Female Becoming Male Female Formerly Male
   Male Becoming Female Male Formerly Female
   No Response Unknown
5. Date of Birth (mm/dd/yyyy): __ __ / __ __ / __ __ __ __
6. Social Security Number: __ __ __ -- __ __ -- __ __ __ __
7. ***Medicaid ID Number:*** __ __ __ __ __ __ __ __ __ __
8. Current Mailing Address: (Ok to send mail) ☐ _____
9. Current Physical Address _____
10. Phone Number(s): HOME: _____ ☐Primary Would you like to receive text
    MOBILE: _____ ☐Primary or automated reminder calls? ☐Yes ☐No
11. Where Were You Born? _____
12. Are You a U.S. Citizen (circle response): Yes No

    Please circle: Can you: Speak - Read - Write in the English language? Yes No Do you need an interpreter? Yes No
13. What language do you prefer to speak? _____
14. Do you have a Legal Guardian? If yes, Name: _____
    Address: _____
15. Emergency Contact/Alternate Contact Name: _____
    Phone Number(s): (ok to call)☐ _____
16. Religious Preference: _____☐ No Response

Demographics *(Additional Information)*

Race(s): Check all that apply

- ❒ American Indian
- ❒ Asian
- ❒ Black/African American
- ❒ Caucasian
- ❒ Native Hawaiian
- ❒ Pacific Islander
- ❒ Other _____

Alaska Native

- ❒ Aleut
- ❒ Athabascan
- ❒ Haida
- ❒ Inupiat
- ❒ Tlingit
- ❒ Tsimshian
- ❒ Yupik
- ❒ Other_____

Ethnicity: Check one

- ❒ Not Spanish/Hispanic/Latino
- ❒ Chicano/Other Hispanic
- ❒ Cuban
- ❒ Hispanic
- ❒ Mexican American
- ❒ Puerto Rican
- ❒ Spanish/Hispanic/Latino

Annual Household Income: Check One

- ❒ 0-$999
- ❒ $1,000-4,999
- ❒ $5,000-9,999
- ❒ $10,000-19,999
- ❒ $20,000-29,999
- ❒ $30,000-39,999
- ❒ $40,000-49,999
- ❒ $50,000 and over

Education: Check one

- ❒ No Schooling
- ❒ If K-11, how many years _____
- ❒ GED
- ❒ High School Diploma
- ❒ Vocational Training
- ❒ Special Ed Ungraded Classes
- ❒ Bachelor's degree (BA, BS)
- ❒ Graduate work (no degree)
- ❒ Master's degree
- ❒ Doctorate/ Professional degree
- ❒ Post-Secondary 1 yr
- ❒ Post-Secondary 2 yrs (Inc. AA degree)
- ❒ Post-Secondary 3 yr
- ❒ Post-Secondary 4+ yrs (no degree)
- ❒ Other _____

For Staff Use Only:
Clinician/Staff Initials: _____
Data Entry Initials: _____

Client Last Name, First Initial: _____
Client ACMHS Number: _____

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Veteran Status: Check one

- ❒ Retired from military; non-combat
- ❒ Never in Military
- ❒ Vietnam Era Veteran; combat
- ❒ Vietnam Era Veteran; non-combat
- ❒ Gulf War Veteran; Combat
- ❒ Iraq War Veteran; Combat
- ❒ Afghan War; Combat
- ❒ In Reserves/Nat. Guard; combat
- ❒ In Reserves/Nat. Guard; non-combat
- ❒ Military Dependent
- ❒ On Active duty; combat
- ❒ On Active duty; non-combat
- ❒ Retired from military; combat
- ❒ Separated, Non-Combat, Honorable Discharge
- ❒ Separated, Non-Combat, Other Than Honorable Discharge
- ❒ Unknown
- ❒ Veteran other eras
- ❒ Not Applicable

Health and Treatment Information *(Admission Profile)*

1. ***Have you ever been in the hospital or residential treatment for substance abuse?*** ____Yes ____No
   If Yes, how many times? _____
2. ***Have you been in the hospital in the last 6 months for medical problems caused by substance abuse?***
   ____Yes ____No If Yes, how many times? _____
3. ***How many inpatient mental health hospitalizations have you had?*** _____
4. ***Only required if FEMALE***: Pregnant: ___Yes ___No ___Unknown ***If Yes***, due date: __ __/ __ __/ __ __
5. ***Injection Drug User***: ___Yes or ___No

Financial Information *(Admission)*

Employment Status: Check One

- ❒ Disabled
- ❒ Employed Full Time
- ❒ Employed Part Time
- ❒ Homemaker
- ❒ In the Armed Forces
- ❒ Not in Labor Force/Other
- ❒ Not Seeking Work
- ❒ Resident/Inmate
- ❒ Retired
- ❒ Seasonal Employee/in season
- ❒ Seasonal Employee/out season
- ❒ Student
- ❒ Unemployed/Not seeking work
- ❒ Unemployed/Subsistence
- ❒ Unemployed/Looking for work
- ❒ Other _____
- ❒ No Response

Primary Income Source: Check One

- ❒ Tribal Assistance Program
- ❒ None
- ❒ Alaska Native Corp Dividends
- ❒ Alimony
- ❒ Alaska PFD
- ❒ Child Support
- ❒ Employment
- ❒ Interest & Other
- ❒ Public Assistance/ Welfare Pay
- ❒ Parent's Income
- ❒ Railroad Retirement
- ❒ Retirement/Survivor/Disability Pension
- ❒ Social Security Disability (SSDI)
- ❒ Self-Employment
- ❒ Supplemental Security Inc (SSI)
- ❒ Spouse/Significant Other's Income
- ❒ Social Security
- ❒ Unemployment Compensation

Other _____

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Admission ~ Financial Info Screen

Expected Payment Source: Check One

- ❒ Aetna
- ❒ AK Native Health Care
- ❒ Blue Cross/Blue Shield
- ❒ CIGNA
- ❒ Client Self Pay
- ❒ HMO
- ❒ Indian Health Services
- ❒ Medicaid
- ❒ Medicare
- ❒ MODA Health
- ❒ No charge
- ❒ Other Government Grant
- ❒ Other Native Health Care
- ❒ Other Private
- ❒ Other Public
- ❒ Sliding Scale, Client Partial Payment
- ❒ Sliding Scale, No Charge
- ❒ Other: _____
- ❒ Unknown

Insurance Type: Check One

- ❒ Indian Health Services
- ❒ None
- ❒ Commercial
- ❒ Medicare Conditionally Primary
- ❒ Group Policy
- ❒ HMO
- ❒ Individual Policy
- ❒ Long Term Policy
- ❒ Litigation
- ❒ Medicare Part B
- ❒ Medicaid
- ❒ Medigap Part B
- ❒ Medicare Primary
- ❒ Other Public Insurance
- ❒ Other Private Insurance
- ❒ Personal Payment (Cash-No Insurance)
- ❒ Supplemental Policy
- ❒ VA insurance
- ❒ Other_____
- ❒ Unknown

Living Arrangement: Check One

- ❒ Assisted Living Facility
- ❒ Correction/Detention Facility
- ❒ Crisis Residence
- ❒ Foster Care
- ❒ Group Home
- ❒ Halfway House
- ❒ Homeless
- ❒ Hospital for Non-Psychiatric Purposes
- ❒ Hospital for Psychiatric Purposes
- ❒ Nursing home
- ❒ Private Residence w/out supportive services
- ❒ Private residence w/supportive services
- ❒ Residential Treatment
- ❒ Shelter
- ❒ Therapeutic Foster Care
- ❒ Transitional Housing
- ❒ Other _____
- ❒ No Response
- ❒ Unknown

Marital Status: Check one

- ❒ Cohabitating
- ❒ Divorced
- ❒ Married
- ❒ Never Married-Single
- ❒ Separated
- ❒ Widowed
- ❒ No Response
- ❒ Not Collected
- ❒ Unknown

Living in Home: Answer both

1. Number of people that live with you: _____
2. Number of children in the household: _____

Admission ~ Legal History Screen

Number of Arrests: In the **past 30** days (***required***) _____

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Admission ~ Intake (continued)

Source of Referral: Check One

- ❒ Alaska Native Hospital (PHS or IHA)
- ❒ Alcohol Detox or Residential Program
- ❒ Alcohol Program
- ❒ Anchorage Correctional Complex
- ❒ Anvil Mountain Correctional Center
- ❒ API
- ❒ ASAP
- ❒ Assisted Living Facility
- ❒ Attorney
- ❒ Community Health Center
- ❒ Correctional Agency (Probation, Parole)
- ❒ Court – CINA Proceedings
- ❒ Court – Civil Proceedings
- ❒ Court – Criminal Proceedings
- ❒ Crisis Recovery Center
- ❒ Dentist
- ❒ Department of Corrections/Jail
- ❒ Developmental Disabled Program
- ❒ Division of Vocational Rehabilitation
- ❒ Drug Detox or Residential Program
- ❒ Drug Program
- ❒ DVSA – Victim Services
- ❒ Emergency Department
- ❒ Employer (EAP)
- ❒ Family or Friend
- ❒ Federal Probation
- ❒ Goose Creek Correctional Center
- ❒ Halfway House
- ❒ Highland Mountain Correctional Center
- ❒ Individual or Self-Referral
- ❒ Internal Referral
- ❒ Juvenile Justice
- ❒ JSAP
- ❒ Ketchikan Correctional Center
- ❒ Not Applicable
- ❒ No Response
- ❒ Nursing Home/Immediate Care Facility
- ❒ Office of Children's Services
- ❒ Other Mental Health (not including psychiatrist), Including School, Church
- ❒ Other CMHC Outpatient Caseload
- ❒ Other Residential/Institutional
- ❒ Other Social/Community Agencies
- ❒ Outreach Team
- ❒ Out of State Court
- ❒ Out of State Medical
- ❒ Out of State Psych or Res. Treatment
- ❒ Partial Care or Day Care Program
- ❒ Peer Support
- ❒ Physician
- ❒ Point Mackenzie Correctional Farm
- ❒ Private Psychiatric Hospital
- ❒ Psychiatrist or Psychiatric Outpatient Clinic
- ❒ Public Health (HS, PHS, Div. of Public Health)
- ❒ Public Safety
- ❒ School
- ❒ Social Services
- ❒ Spring Creek Correctional Center
- ❒ Supervised Apartment
- ❒ Therapeutic Court
- ❒ Transitional Housing
- ❒ Tribal Court
- ❒ Tribal Health Authority
- ❒ Tribal Health Facility
- ❒ V.A. Hospital
- ❒ Village Health Aide
- ❒ Wildwood Correctional Center
- ❒ Youth Court
- ❒ Yukon Kuskokwim Correctional Center
- ❒ Other _____

Admission ~ Intake (STAFF COMPLETES THIS SECTION)

1. ***Admission Date***: __ __ /__ __ /__ __ (*same as date of Assessment)* Treating ***Here for***: Mental Health (always)
2. ***Admission Type***: ___First Admission ___Readmission ***Mental Health Problem***: YES (always)
3. ***Admission Staff***: _____ ***Opioid Replacement Therapy Planned***: NO (always)
4. ***Client Type***: ___ Adult Severely Mentally Ill w/Substance Use Disorder
   ___ Adult Severely Mentally Ill w/NO Substance Use Disorder
   ___ Adult Emotionally Disturbed w/Substance Use Disorder
   ___ Adult Emotionally Disturbed w/NO Substance Use Disorder
   ___ Youth Emotionally Disturbed w/Substance Use Disorder
   ___ Youth Emotionally Disturbed w/NO Substance Use Disorder
   ___ Youth Severely Emotionally Disturbed w/Substance Use Disorder
   ___ Youth Severely Emotionally Disturbed w/NO Substance Use Disorder
   ___ Youth or Adult w/Substance Use Disorder ONLY

ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES, INC. (ACMHS)
FAIRBANKS COMMUNITY MENTAL HEALTH SERVICES, INC. (FCMHS)

CLIENT FINANCIAL POLICIES

CLIENT NAME: _____ CLIENT #: _____

Assumption of Responsibility

The undersigned, responsible party, agrees whether he/she signs as guarantor or as Client that in consideration of services to be rendered, to the Client named above, that the responsible party will guarantee the payment of all charges for such services and incidentals incurred by said Client. Delinquent fees may be turned over to a collection service, and reported to the Credit Bureau of Alaska.

The undersigned, responsible party, agrees to pay the Organization (ACMHS/FCMHS) the stated percentage of the actual charge per visit that is set in the current fee set. The agreed upon fee is payable at the time of service.

The undersigned, responsible party, agrees to advise the Organization of any changes in financial status.

Authorization to Release Information

The undersigned, responsible party, hereby authorizes the Organization to release demographical and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

Insurance Information

It is the practice of this Organization to accept most major medical insurance companies, Medicaid, and Medicare. It is the Organization's goal to provide fast and efficient billing as a ***courtesy*** to the client. Our Organization needs the clients' and/or responsible parties help to accomplish this goal. The clients' providing complete and accurate insurance information is necessary. All clients' must complete the ACMHS Client Registration Form and give necessary information before seeing the Organization staff. It is the clients' responsibility to notify the Organization immediately if insurance or financial information changes.

Client Signature	Date

Responsible Party Signature	Date
Please Print Name	Relationship to Client

Revised 8/16/08, Rev. 4/26/17

Informed Consent for Services by Student Interns

I, _____ (print name) client, parent or guardian, or authorized representative of _____ (print client name), understand that this Organization (ACMHS/FCMHS) trains undergraduate and advanced graduate students from the mental health profession who are not yet licensed in Alaska.

I understand that all students are supervised by a minimum of a Masters prepared Clinical Supervisor. Supervision includes face-to-face supervision sessions, reviewing and co-signing treatment plans, progress notes, and signing off on all other documents that go into your clinical record.

I understand that I have the right to know the name of the Student Intern, their supervisor and how to contact her or him; the staff member you meet with will provide this information upon request.

☐Decline Consent for Services by Student Interns _____ _____
Signature Date

Your signature below indicates: 1) you have read the information in this document and consent to services provided by the Organization's Student Interns; 2) your Protected Health Information (PHI) is strictly confidential and is protected by Federal and State regulations (42 CFR Part 2; 45 CFR 160, 162, and 164; and 7 AAC 71.215).

_____ _____
Client Signature/Parent or Guardian or Authorized Representative — Date

_____ _____
Name of Student (Print) — Date

_____ _____
Name of Supervisor (Print) — Date

Staff Completed:
Client Name:
Client ID:

Joint Notice of Privacy Practices
Anchorage & Fairbanks Community Mental Health Services

4020 Folker Street, Anchorage AK 99508
907-563-1000
1423 Peger Road, Fairbanks, AK 99709
907-371-1300

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

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

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

This Joint Notice of Privacy Practices is based on a template provided by the Office of Civil Rights and includes some information that does not apply to ACMHS and its wholly owned subsidiaries. For example, we do not provide inpatient (hospital care) so that we do not provide a 'hospital directory.'

We do not create or maintain psychotherapy notes separate from what is in your medical record.
We never market or sell personal information

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

July 1, 2017

This Notice of Privacy Practices applies to the following organizations.

This Notice applies to Anchorage Community Mental Health Services and its wholly owned subsidiaries that are Covered Entities under HIPAA including Fairbanks Community Mental Health Services. ACMHS and FCMHS are Affiliated Covered Entities (ACE). Other subsidiary entities that do not provide healthcare services are not covered by this Notice, for example Seeds of Change.

For questions you may contact the following Privacy Officials:
Pamela Kennedy, LPC, CHPC, Privacy Officer, 4020 Folker Street, Anchorage, Alaska 99508
907-563-1000
Krista Hart, Deputy Privacy Officer, 1423 Peger Road, Fairbanks, Alaska 99709, 907-371-1300

Anchorage Community Mental Health Services, Inc., 4020 Folker Street, Anchorage, Alaska 99508
Fairbanks Community Mental Health Services, LLC, 1423 Peger Road, Fairbanks, Alaska 99709
Privacy Officer: Pamela Kennedy, CHPC, 907-563-1000--Deputy at FCMHS: Krista Hart, 907-371-1300

Appointment Policy and Agreement

Scheduling an appointment serves as a reservation of time when we work with you in reaching your treatment goals. We are a team, so your regular attendance and active participation are important. Unfortunately, late arrivals for appointments prevent us from providing the highest quality care possible. Also, we are unable to refill prescriptions if we do not see you on a regular basis because of "no shows" and if you do not complete necessary laboratory work.

Please see below for the appointment guidelines which will assist you in receiving the highest quality of service and allow us to provide such service:

1. I agree to call and cancel appointments at least 24 hours in advance, or the day before any scheduled appointment that I cannot keep. Any appointment canceled on the day of that appointment, or that I am not present for at the start time of the appointment, will be considered a "no show." *Emergencies will be taken into consideration*.
2. I agree to arrive on time for my appointments. I understand that late arrival may prevent me from being seen by a provider due to time constraints in which case I would need to reschedule my appointment. This may count as a "no show."
3. I understand that subsequent no shows for medical provider appointments may result in no further scheduled appointments. If that happens, I will have the option to walk in and wait for a provider to see me and I understand there is no guarantee that an opening will be available with my preferred provider and/or that I will not have a long wait.
4. I understand that no further prescription refills will be available until I am seen in person by a provider.

Our mission is to promote wellness through behavioral health care services. Your health and safety are essential, and we are committed to be your provider of choice.

Consumer Grievance Process

It is the policy of our Organization (ACMHS/FCMHS) to treat all of our clients with dignity, respect, individuality, and with consideration for privacy. The Organization will provide all of its clients a process for reporting grievances in a respectful, timely, and fair manner without fear of retaliation.

1. Clients are asked and encouraged to review the form entitled *Client Rights and Responsibilities.* This form will be signed by the client at intake.

2. Clients or family members may ask someone to help them and be present during any/all grievance meetings. If asked, the Organization will provide help to clients who wish to file grievances.

3. The Organization will provide helpful resources to clients interested in filing grievances including the Disability Law Center, the Alaska Mental Health Consumer Web, NAMI Anchorage, NAMI Fairbanks, and NAMI Alaska**,** or any other known resource.

4. Clients are encouraged to talk about any concerns or grievances they have about their care and treatment at this Organization with their primary provider and/or that person's supervisor to work to fix the issue. If the problem cannot be fixed as described above, the client should fill out the Consumer Complaint form and submit it in a sealed envelope to the Deputy Privacy Officer.

5. The Deputy Privacy Officer will send a letter to the client within five (5) working days of receiving the complaint if not resolved at the departmental level. The letter will inform the client that the complaint has escalated to a grievance, has been received and the review process has been started. A written response to the grievance will be provided within thirty (30) working days after the review begins. If unable to resolve the grievance in thirty (30) working days, the Deputy Privacy Officer will explain the delay to the client in writing or by phone call.

6. For clients receiving publicly funded services, grievances unresolved to the client's satisfaction within thirty (30) calendar days shall be reported to the Division of Behavioral Health (1-800-770-3930 or 907-269-3600). Individuals may file a complaint with the Organization and the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated.

7. We have a "no tolerance" policy for abuse, neglect or intimidation being used to stop the filing of a grievance. We also do not tolerate retaliation for filing a grievance. Any report of abuse, neglect, or threats will be looked into and immediately reported to the Chief Executive Officer and the Organization's Board of Directors through the Corporate Operations committee. For clients receiving publicly funded services, the same will be reported to the Division of Behavioral Health.

8. The Client Grievance procedure will:
   a. be available to all clients, legal guardians and to those denied services;
   b. be summarized in a plain language form and given to the client or legal guardian and an acknowledgment signature form placed in the client's chart;
   c. be prominently displayed in all Organization facilities.

9. Findings of grievances will be reported by the Deputy Privacy Officer to the Chief Executive Officer and the Organization's Board of Directors' Corporate Operations Committee. Reports will be a summary of all grievances received in the quarter.

CONSUMER RIGHTS AND RESPONSIBILITIES
ANCHORAGE AND FAIRBANKS COMMUNITY MENTAL HEALTH SERVICES

YOUR RIGHTS

1. To get services without being treated unfairly due to race, religion, gender, age, place of origin, English proficiency, sexual orientation, marital status, or physical or mental abilities.

2. To be respected and treated with dignity and respect.

3. To be involved in your Treatment Plan, including the right to say no to certain services or to ask for specific services. If services cannot be provided, you have the right to be told why the service is not being provided or to be referred elsewhere for the service.

4. To be told by the person prescribing medications the name, purpose, possible side effects and drug interactions of any medication prescribed. You have a right to be told the risks and benefits of the medication, and the risk and benefit of not taking the medication.

5. To ask us to contact you by some method other than calling you at a home or work number. (e.g. calling a neighbor and leaving a message, email, etc.).

6. To have your health information kept confidential except as required or allowed by law and to review or get a copy of your records. Our Notice of Privacy Practices gives details about these rights.

7. To refuse experimental treatments, nonstandard treatment and participation in education or demonstration programs or research.

8. To make complaints or file a grievance without fear of retaliation.

YOUR RESPONSIBILITIES

1. To tell us why you are seeking services, about your problems, past illnesses, medications, and history.

2. To give complete, accurate and updated information to keep your clinical record current.

3. To ask questions about any information you do not understand.

4. To take an active role in your treatment (this includes families or guardians in the case of minor clients) and to work on treatment plan goals developed by you and your team.

5. To show respect for others, including respect for the confidentiality of others you see when you are here.

6. To talk about your concerns, complaints or grievances directly to staff and work to fix the problem.

7. To immediately report abuse, unethical or unprofessional staff behavior to Management.

8. To be financially responsible by giving all insurance information, current mailing address, paying bills, asking for financial counseling if needed, and following through with payment plans.

9. To come on time for appointments and to give at least 24 hours advance notice to cancel an appointment.

If you do not come on time for scheduled appointments or if you cannot be found by outreach staff for over 30 days or by case managers for 60-90 days, you may be discharged or be required to come during walk-in clinic time. If you are discharged for non-attendance you may ask to be re-admitted through the intake process.

Acknowledgement of Receipt of:
HIPAA Notice of Privacy Practices; Consumer Rights & Responsibilities; Consumer Grievance Process; and Appointment Policy and Agreement

I acknowledge that I have received a copy of the **ACMHS/FCMHS HIPAA Notice of Privacy Practices** and have been given the chance to ask questions about it.

_____	_____	_____
Signature of Patient, Parent, Legal Guardian or Personal Representative	Printed Name	Date

I acknowledge that I have received a copy of the **Consumer Rights & Responsibilities** and have been given the chance to ask questions about it.

_____	_____	_____
Signature of Patient, Parent, Legal Guardian or Personal Representative	Printed Name	Date

I acknowledge that I have received a copy of the **Consumer Grievance process** and have been given the chance to ask questions about it.

I acknowledge I have received the **Appointment Policy and Agreement Form** and have been given the chance to ask questions about it.

_____	_____	_____
Signature of Patient, Parent, Legal Guardian or Personal Representative	Printed Name	Date

_____	_____	_____
Staff Witness	**Printed name**	**Date**

ADMIN 301-12 AND 309-12
Rev: 8/12, 11/16, 03/19

Staff Completed:
Client Name:
Client ID:

Anchorage Community Mental Health Services, Inc. /Fairbanks Community Mental Health Services, LLC.
Authorization to Release Health Information

☐ Folker – Main Center - Adult Services | 4020 Folker Street Anchorage, AK 99508 | Ph. 907.563.1000 Fax 907.375.3115
☐ Family Services – On Target - PLL – AK Child Trauma Ctr – Little Tykes - AYA| 4045 Lake Otis Pkwy STE 101 | Anchorage, AK 99501 | Ph. 907.561.0954 Fax 907.375.3115
☐ Ingra Adult Services – IDP – Housing & Engaging Svs. |1432 Ingra Street | Anchorage, AK 99501 | Ph. 907.562.7900 Fax 907.375.3115
☐ FCMHS – Fairbanks |1423 Peger Road | Fairbanks, AK 99709 | Ph. 907.371.1300 Fax 907.371.1386

Name_____DOB:_____SSN:_____
(Name of client whose information is being released) (Optional)

Previous Name(s) _____
(List any and all)

I, ____ Client ____ Parent ____ Legal Guardian hereby authorize

☐ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES or ☐Fairbanks Community Mental Health Services to:
☐Release Information To: ☐ Obtain Information From:

Name: _____Phone#_____

Address: _____Fax#_____

The following information: ☐written ☐verbal

PURPOSE OF INFORMATION (Include client/parent/guardian initials)		INFORMATION TO BE RELEASED / REQUESTED	
☐ ____Treatment Planning	☐ ____Personal Use	☐ Admissions/Intake Summary	☐ Lab Results
☐ ____Continued Treatment	☐ ____Legal Use	☐ Discharge Summary	☐ Substance abuse Tx
☐ ____Coordinate Treatment		☐ Treatment/Safety Plan	☐ Medication Records
☐ ____Benefits/Supports		☐ Psychiatric Evaluation	☐ Videography
☐ ____Other (Specify) _____		☐ Medical Progress Notes	☐ Other (Specify)_____
_____		☐ Clinical Progress Notes	
		☐ Case Management Notes	Date Range_____to_____

- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR 164.524, 42CFR Part 2.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- I understand that the information released may include information regarding Psychiatric Treatment, Substance Abuse Treatment and/or HIV. If I have questions about disclosure of my health information, I can contact ACMHS Clinical Records at 563.1000.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to ACMHS Clinical Records at 563.1000.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand and agree to pay the costs incurred by ACMHS in preparing a copy of records I may request for myself as allowed by State and Federal guidelines.

_____ By initialing this section I am allowing the information to be disclosed one time. This authorization will expire 90 days from the date of my signature, unless otherwise indicated or revoked.

Unless otherwise indicated or revoked this authorization will expire 1 year from my signature date or in: _____ days. (must be less than 12 months)

_____ _____
Client Signature (Required for ANY substance use release) Date

_____ _____ _____ _____
Relative/Guardian/Authorized Person Printed Name Relationship to Client Date

_____ _____
Witness Date

Copy must be offered to client: ____ Accepted ____Refused

SERVICE PROVIDER TO COMPLETE THIS SECTION			
ACTION TO BE TAKEN:			
☐ Send For Records	☐ Send ROI Only	☐ Release ACMHS/FCMHS Records	☐ File ROI Only

Anchorage Community Mental Health Services, Inc. /Fairbanks Community Mental Health Services, LLC.

Emergency Contact - Authorization to Release Health Information

☐ Folker – Main Center - Adult Services | 4020 Folker Street Anchorage, AK 99508 | Ph. 907.563.1000 Fax 907.375.3115
☐ Day Break Adult Care Services | 9210 Jupiter Drive | Anchorage, AK 99507 | Ph. 907.346.2234 Fax 907.375.3115
☐ Family Services – On Target - PLL – AK Child Trauma Ctr – Little Tykes - AYA | 4045 Lake Otis Pkwy STE 101 | Anchorage, AK 99501 | Ph. 907.561.0954 Fax 907.375.3115
☐ Ingra Adult Services – IDP – Housing & Engaging Svs. |1432 Ingra Street | Anchorage, AK 99501 | Ph. 907.562.7900 Fax 907.375.3115
☐ FCMHS – Fairbanks |1423 Peger Road | Fairbanks, AK 99709 | Ph. 907.371.1300 Fax 907.371.1386

Name_____DOB:_____SSN:_____
(Name of client whose information is being released) (Optional)

Previous Name(s) _____
(List any and all)

I, ____ Client ____ Parent ____ Legal Guardian hereby authorize

☐ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES or ☐Fairbanks Community Mental Health Services to:
☐Release Information To: ☐ Obtain Information From:

Emergency Contact Name: _____Phone Number: _____☐Decline Emergency Contact

Address: _____

The following information: ☐ written ☐ verbal

PURPOSE OF INFORMATION (Include client/parent/guardian initials)	INFORMATION TO BE RELEASED / REQUESTED
☐ ____Continued Treatment ☐ ____Legal Use ☐ ____Coordinate Treatment ☐ ____Other (Specify)	☐ Minimum Necessary ☐ Other (Specify) _____

- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR 164.524, 42CFR Part 2.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- I understand that the information released may include information regarding Psychiatric Treatment, Substance Abuse Treatment and/or HIV. If I have questions about disclosure of my health information, I can contact ACMHS Clinical Records at 563.1000.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to ACMHS Clinical Records at 563.1000.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand and agree to pay the costs incurred by ACMHS in preparing a copy of records I may request for myself as allowed by State and Federal guidelines.

_____ By initialing this section I am allowing the information to be disclosed one time. This authorization will expire 90 days from the date of my signature, unless otherwise indicated or revoked.

Unless otherwise indicated or revoked this authorization will expire 1 year from my signature date or in: _____ days. (must be less than 12 months)

_____ _____
Client Signature (Optional for Minors/Adults with Guardians) Date

_____ _____ _____ _____
Relative/Guardian/Authorized Person Printed Name Relationship to Client Date

_____ _____
Witness Date

Copy must be offered to client: ____ Accepted ____Refused

SERVICE PROVIDER TO COMPLETE THIS SECTION
ACTION TO BE TAKEN: ☐ Send For Records ☐ Send ROI Only ☐ Release ACMHS/FCMHS Records ☐ File ROI Only

Anchorage Community Mental Health Services / Fairbanks Community Mental Health Services
CONSENT FOR ELECTRONIC COMMUNICATIONS

Email and texting

Our Organization (ACMHS / FCMHS) is able use Email and some texting to communicate with clients, upon mutual agreement between the provider and the client. This can be very helpful and convenient but is not guaranteed to be secure.

E-mail

We use an encrypted secure method to send and respond to Emails called CISCO. CISCO requires a onetime registration (at no cost to the Email recipient) to create a password. **If you do not wish to register with CISCO, we cannot communicate via Email with you.**

We will use the minimum necessary amount of Protected Health Information (PHI) to respond to any emails you may send to us. We will make every effort to keep PHI secure, in accordance with State and Federal law.

Email communication is a convenience and not appropriate for all circumstances. Please remember the following:

- **Emails are not to be used for emergencies or time-sensitive issues**.
- **Emails are not to be used as a therapy session**.
- **No one can guarantee the privacy of e-mail messages**.
    - For example, if your work e-mail is used, even though sent securely by us, your employer may have the right to access any e-mail received or sent from your work computer.
- **The Organization is not responsible for access of PHI due to your sharing or loss of your User ID and password, or an unattended email account.** Any PHI accessed in this manner is no longer protected by our privacy practices.

Texting

Texting is a convenient method of communicating brief information, but it is not secure. We have a system available for you to opt into that texts your next appointment as a courtesy reminder. This requires you to have a cell phone that is able to make and receive text messages. As another courtesy for our clients, select staff have a work cell phone available during **business hours only** for non-emergency texting.

Texting is:

- Not for emergencies
- Not to be used for therapy services
- **No one can guarantee the privacy of text messages**.
    - For example, if you use a work phone, or your work has the right to access your phone, your employer may have the right to view your text messages.
- May not be responded to immediately
- Can be used for messaging with your provider if you are running late to an appointment
- Can be used for resource reminders (e.g. breathing exercises; food bank hours; grounding techniques, etc.)

You are not required to use email or texting.

Fax Policy

The use of faxing can be very helpful and convenient but is not guaranteed to be secure. There is some risk that any PHI that may be contained in such fax may be disclosed to, or intercepted by, unauthorized third parties. We will use the minimum necessary amount of PHI and will make every effort to keep your information secure as required by law.

Anchorage Community Mental Health Services / Fairbanks Community Mental Health Services
CONSENT FOR ELECTRONIC COMMUNICATIONS

Communication Consent

If you personally wish to communicate with us via Email, Fax, or texting please **initial the option below** and provide a valid email address and/or fax number.

_____ I do wish to communicate via email. Email address: _____

_____ I do wish to communicate via text. Cell number: _____

_____ I do wish to communicate via fax. Fax number: _____

OR **initial on the following page** if you do not want to communicate via Email, Texting or Fax:

_____ I **do NOT** authorize the following forms of electronic communication between me and my provider:

_____ Email _____Texting _____ Fax

I understand the risks associated with electronic communications and initialed my communication preferences above. If I have authorized electronic communications, I do so with the following understanding:

- **Electronic communication methods can be misdirected to or intercepted and disclosed by unintended third parties and may not be a confidential form of communication. I understand and agree that electronic communication is being used for the convenience of myself and the ORGANIZATION does not warrant the confidentiality or security of this transmission**.

By signing below, you consent to the conditions described herein and agree to adhere to the policies set forth above, as well as any other guidelines that the Organization may impose for using electronic communications.

Signature Date Client Name Relationship to Client

Anchorage Community Mental Health Services / Fairbanks Community Mental Health Services
CONSENT FOR ELECTRONIC COMMUNICATIONS

Telehealth Services

Telehealth services are provided for the convenience of our clients. Telehealth service is not required and is only used upon mutual agreement between provider and client. Telehealth services are subject to the following:

- Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider determines that telehealth is not adequate for a particular issue, the provider may choose to terminate the session and request an in-person session.
- **Telehealth services will be scheduled in advance**.
- Telehealth services provided via computer should be accessed through a safe and secure connection. Be sure to use a computer that is in a confidential or private area and always fully close all online counseling sessions when they are complete.
- Telehealth services may also include online functionality, such as posting of notes or chat logs during the session. This information may be printed by your provider, and if so, it will be treated as confidential.
- If telehealth services cannot be conducted due to technical difficulties, you should immediately contact your provider to schedule a new session.
- **Telehealth services are not appropriate for emergency situations**.
- Some videoconferencing services, such as Skype, may retain certain personal information for its users. This could include user contacts and addresses, and other personal information you provide to the service. You should review the privacy policy for the internet service provider if you have any questions about the confidentiality of such information.

Telehealth Consent

Using telehealth services is entirely voluntary and will not impact the quality of care you receive from the Organization should you decide not to use these services.

ACMHS/FCMHS is not liable for any claims and/or damages arising from following:

i. Interruption in the ability to conduct telehealth services due to technical difficulties, technical maintenance, or system failure.
ii. Access by friends, family members or other third parties who may enter the room on the client side during telehealth sessions.
iii. Breaches of privacy and security due to the fault of the third-party videoconferencing provider (such as Zoom, or Skype, etc.).

I understand the risks associated with telemedicine and initialed my preference above. If I have authorized telemedicine services, I do so with the following understanding:

- **Electronic communication methods can be misdirected to or intercepted and disclosed by unintended third parties and may not be a confidential form of communication. I understand and agree that electronic communication is being used for the convenience of myself and the ORGANIZATION does not warrant the confidentiality or security of this transmission**.

By signing below, you consent to the conditions described herein and agree to adhere to the policies set forth above, as well as any other guidelines that the Organization may impose for using electronic communications.

Signature Date Client Name Relationship to Client

ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES
FAIRBANKS COMMUNITY MENTAL HEALTH SERVICES
Consumer Information on Safety Guidelines and Procedures

We wish to make your visit comfortable and helpful. In order to make the agency a safe place for everyone, the following guidelines will be followed:

1. All persons are to be treated with dignity and respect.

2. Physical or Verbal outbursts are not allowed.
    a. A physical outburst includes
        i. An unwanted touch whether in anger or not
        ii. Throwing any object whether in anger or not
        iii. Any other action or behavior that interferes with the safety of others.

    b. A verbal outburst includes
        i. Yelling, raising your voice, name calling or any spoken threat to one of our staff or any other person in our buildings, on our property or in the community while services are being provided.
        ii. Any spoken word that disrupts the ability of staff to do their job, or the positive experience of others.

When someone violates the rules by having a physical or verbal outburst one or more of the steps below will be taken, not necessarily in this order:

1) You may be asked politely to stop the verbal or physical outburst.
2) If the outburst is severe, or you do not stop when asked you may be asked to leave the premises.
3) If you do not leave the premises when asked, or staff or others feel unsafe the Anchorage Police Department may be called.
4) In rare instances, and as a last resort, our staff may need to keep you from hurting yourself or others using *non-violent physical crisis intervention* techniques to manage the situation.* This type of staff response in only used when a person has lost control and verbal aggression has turned into physically assaultive behavior.

Most of the time, everyone who visits one of our buildings participates in our programs and services in positive ways that do not require these steps. Please help us maintain a pleasant experience for everyone who comes here by avoiding verbal or physical outbursts.

*All our employees are trained in the *Non-violent Physical Crisis Intervention Training Program* by the Crisis Prevention Institute, Inc. (CPI). The philosophy behind both the program and the techniques is to provide for the *care, welfare, safety and security* of everyone. This professional training is provided for our staff to assist in de-escalating acting out behavior that can be either verbal or physical to keep people from hurting themselves or others.

Anchorage Community Mental Health Services
Fairbanks Community Mental Health Services

Consumer acknowledgement and consent

I acknowledge that I received a copy of the Safety Guidelines and Procedures and consent to these steps to keep myself and others safe.

_____	_____	_____
Consumer printed name	Signature	Date
_____	_____	_____
Parent / Guardian printed name & relationship	Signature	Date
_____	_____	_____
Staff Witness	Signature	Date

Staff Completed:
Client Name:
Client ID: