State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Addictive & Mental Disorders Division
Medicaid Enrollment Application

☐ MHSP (Detention Center)
☐ WASP (Standard Medicaid)

Mental Health Services Plan (MHSP) and Waiver for Additional Services and Population (WASP)

Please complete this form with information specific to the applicant seeking services
NOTE: This form needs to be submitted with the Clinical Eligibility Form

APPLICANT INFORMATION		
Applicant ID/SSN:	DOB:	Gender:
Applicant Name: Last:	First:	Middle:
Mailing Address:	City:	State:
County:	Zip:	
Telephone #:		
Tribal Affiliation:	Race:	Marital Status:

For Detention Center Use:
Detention Center_____City/County_____Discharge/Disposition Date_____
First Date of Service Seen in Detention Center _____

LIST EVERYONE WHO RESIDES WITH APPLICANT. (Attach additional sheet if more than three people live with applicant.)

Last Name, First, Middle Initial	How is this person related to applicant?	Sex	Birth Date	Education Level	Social Security Number
1.					
2.					
3.					

INCOME: SUBMIT VERIFICATION OF **ALL** INCOME FOR ALL HOUSEHOLD MEMBERS
List all income and benefits you, your spouse, dependents, or other household members receive from any source (i.e., employment, Social Security, SSI, Pensions, VA, Child Support, BIA, etc.) **2 months** of pay stubs.

Name	Source	Gross Amount of Income	How Often Received

If zero income, what is your source of support?_____
Do you anticipate this income to change in the next two months? ☐Yes ☐No
If yes, what is the expected change? _____
Number of family members dependent on family Income? _____

Applicant Name: Last: _____ First: _____

PLEASE LIST THE MENTAL HEALTH CARE PROVIDER(S) AUTHORIZED TO RECEIVE COPIES OF MHSP/WASP CORRESPONDENCE

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

DO YOU HAVE HEALTH INSURANCE COVERAGE? ☐Yes ☐No

(If yes, please complete the following for all insurance coverage including Medicare. **ATTACH COPY OF CARDS)**

Name of Insured: _____ Relationship to Applicant: _____

Insured's SSN: _____ Policy #: _____ Group #: _____

Insurance Carrier Name: _____ Start Date: _____

ARE YOU RECEIVING MEDICARE: ☐Yes ☐No Medicare ID #

I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they shall form a part of the insurance contract for which I am applying. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, organization, institution or person that has any records or knowledge of my health to disclose to Department of Public Health and Human Services (DPHHS) or its designee any such information. A photographic copy of this authorization shall be as valid as the original. I may revoke this authorization at any time except to the extent that the person or entity making the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from the date that I sign.

I agree to notify DPHHS of any changes of income, family size or other insurance coverage within 30 days of the change.

Signature of Applicant: _____ **Date:** _____

This application is considered complete only when income documentation has been attached.

Please Mail or Fax the Checklist, Application and Clinical Eligibility Form to:

Addictive & Mental Disorders Division

Mental Health Services Bureau
PO Box 202905, Helena MT 59620-2905

Please send through secure method (such as ePass) to:
HHSAMDDMHSPWaiver@mt.gov

Fax: 1-406-444-7391 or
1-406-444-4435 Questions? Call
1-406-444-3964

Print Form **Save Form** **Reset Form**

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
ADMISSION FORM

Name: _____ **Social Security Number:** _____
(Last) *(First)*

SOURCE OF REFERRAL
_____1. Self
_____2. Private MH Professional
_____3. Courts
_____4. Schools
_____5. Social/Community Agency
_____6. Other
_____7. Clergy
_____8. Non-psychiatric Physician
_____9. Montana State Hospital
_____10. Residential Facility
_____11. Other Mental Health Center
_____12. Law Enforcement
_____13. Crisis Center
_____14. Hospital Emergency Room
_____15. Native American Agency
_____16. Homeless Shelter
_____17. Alcohol/Drug Treatment Center
_____18. Agency of the Elderly
_____19. Agency for Children
_____20. Developmental Disabilities
_____21. Veteran=s Administration
_____22. EAP

RESIDENTIAL ARRANGEMENT
_____1. Homeless
_____2. Jail
_____3. Hospitalization
_____4. Nursing Home
_____5. Single Room Occupancy (Transient Hotel)
_____6. Shelter/Mission
_____7. Personal Care Home
_____8. Mental Health Group Home
_____9. Non-Mental Health Group Home
_____10. Foster Home
_____11. Living with others (in their care)
_____12. Supported Independent Living
_____13. Living Independently With Others
_____14. Living Independently
_____15. Other (Please Specify in File)
_____16. Therapeutic Foster Care
_____17. Residential Treatment Facility

RECENT MH SERVICES
_____1. MT State Hospital
_____2. Other Inpatient Care
_____3. Partial Hospitalization
_____4. Outpatient
_____5. No Prior Services
_____6. Unknown
_____7. This Facility
_____8. Psychiatric or Other Residential

EMPLOYMENT AT ADMISSION
_____1. No Interest in Work
_____2. Unemployed but desiring & able to Work
_____3. Involved in Day Treatment
_____4. Job Corps
_____5. Being Evaluated by Voc Rehab Services
_____6. Employed in Ongoing Volunteer Work
_____7. Employed in Sheltered Workshop
_____8. Transitional Employment Program
_____9. Supported Employment
_____10. Part-time Gainful Employment
_____11. Full-time Gainful Employment
_____12. Homemaker
_____13. Retired: Age 55 or Over
_____14. Other
_____15. Student/Preschool
_____16. Disabled

YEARS OF EDUCATION:_____Years

EDUCATIONAL STATUS
_____1. No Formal Education Activity
_____2. Adult Education Classes/GED
_____3. Attends Vocational School
_____4. Attends College Part-time
_____5. Attends College Full-time
_____6. Other
_____7. Public School
_____8. Home School
_____9. Private School For General Population

DEVELOPMENTAL DISABILITY
_____1. Yes
_____2. No
_____3. Unknown

MOST SEVERE PRESENTING PROBLEM AT TIME OF ADMISSION
_____1. Martial/Family Problems
_____2. Social/Interpersonal (not family)
_____3. Problems Coping with Daily Activities
_____4. Medical/Somatic
_____5. Depression or Mood Disorder
_____6. Attempt, Threat, or Danger of Suicide
_____7. Alcohol
_____8. Drug
_____9. Involved w/Criminal Justice System
_____10. Eating Disorder
_____11. Thought Disorder
_____12. Abuse/Assault/Rape Victim
_____13. Runaway Behavior

HOMELESS IN THE LAST 6 MONTH
_____1. Yes
_____2. No
_____3. Unknown

ON PROBATION OR PAROLE DURING LAST
_____1. Yes
_____2. No

CHRONICAL MEDICAL PROBLEMS IN THE LAST YEAR
_____1. Yes
_____2. No

MEDICAL EXAM IN LAST 3 MONTHS
_____1. Yes
_____2. No

DENTAL EXAM IN LAST 3 MONTHS
_____1. Yes
_____2. No

VISION EXAM IN LAST 3 MONTHS
_____1. Yes
_____2. No

NEW GENERATION MEDS
_____1. Yes
_____2. No

NEW GENERATION MEDS ARE
Clozaril (clozapine)
Zyprexa (olanzapine)
Fumarate Seroquel (quetiapine)
Risperdal (risperidone)
Geodon (ziprasidone)

SMOKING STATUS
_____1. Current Every Day Smoker
_____2. Current Some Day Smoker
_____3. Former Smoker
_____4. Never Smoker

ELIGIBILITY DETERMINATION
_____1. SSI Due to Mental Illness
_____2. SSI Not Due to Mental Illness
_____3. SSDI Due to Mental Illness
_____4. SSDI Not Due to Mental Illness
_____5. Does Not Apply

SNAP BENEFITS
_____1. Yes
_____2. No

TANF BENEFITS
_____1. Yes
_____2. No

Eastern Montana Community Mental Health Center
CONTRACT FOR PAYMENT OF SERVICES

CLIENT NAME: _____

The Eastern Montana Community Mental Health Center is a private, non-profit corporation financed largely by the collection of client fees.

1. State Funded Coverage/Self Pay:

_____ I am Medicaid eligible. I agree to notify EMCMHC regarding any changes in my eligibility.

_____ I am Medicaid eligible. I agree to pay **$150.00** for PFL Group.

_____ I am eligible for the Chemical Dependency Service Plan. I agree to provide monthly income verification.

_____ I qualify for a reduced monthly rate based on the Sliding Fee Scale.

_____ I am applying for HELP Medicaid or HELP TPA thru HealthCare.gov.

☐ **I am FULL FEE** ☐ **$350/PFL** ☐ **$150/MIP** ☐**$200/CD EVAL** ☐**OTHER $**_____

2. Insurance/Medicare Coverage:

- I understand that I am responsible for payment of all services received at the Center. After I complete and sign an insurance information form, the Center will submit a claim to my insurance company for services rendered. Payment from the insurance or Medicare will be sent directly to the Center. If I receive payment and do not remit the payment to the Center in a timely manner, I understand that I will be billed for the full amount of services.

_____ I agree to pay the full difference between what my insurance/Medicare pays.

3. No Third Party Coverage Payment Plan:

_____ I agree to pay full fee for all Center services according to my monthly payment plan:

☐ $25 per mo. $☐ 50 per mo. ☐ $75 per mo. ☐ $100 per mo. ☐ Payment in Full

(The above monthly payment plan is based on poverty guideline)

4. Cancellations / Broken Appointments

- I agree to be responsible for notifying the Center at least 24 hours in advance if I am unable to keep my appointment. I understand that I will be charged $100.00 ($150.00 for nurse practitioners) for every broken appointment without the 24 hour notification. If I break two appointments without advance notice the Center may not schedule a third appointment.

- I understand that should my circumstances change, I am responsible to inform Eastern Montana Community Mental Health Center. I understand that I will be billed full fee until the updated financial information has been received by the Center. I also understand that should I fail to make the above agreed upon payments, Eastern Montana Community Mental Health Center can pursue legal action to collect the outstanding balance in my account, and I will be responsible for court costs and attorney fees.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS, AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE AND CORRECT, AND I AGREE TO THIS PAYMENT CONTRACT AND ITS TERMS.

Signature of client or responsible party: _____ Date: _____

Address of client or responsible party: _____

Signature of Staff: _____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

Eastern Montana Community Mental Health Center
Administration Office
2508 Wilson Street
PO Box 1530
Miles City, MT 59301
406-234-0234

All Consumers,

In an effort to better serve you we have contracted to have text and email reminders sent to you. If you would like to opt in or out please complete the following information.

Name: _____

Cell Number: _____

Email Address: _____

Reminder Days Ahead (put 0 to be notified 4 hours prior to appointment): _____

How would you like to be reminded?

☐ Email

☐ Text

☐ Email and Text

☐ None - I opt out of receiving reminders

Cancellation Policy: I understand that it is my responsibility to keep my scheduled appointments with my EMCMHC provider. I will call at a minimum 24 hours in advance to reschedule any conflicting appointments. EMCMHC employees may provide support with appointment reminders through phone calls, text and or email. However, if upon review of my attendance history, I "no show" or "cancel" on a consistent basis or my EMCMHC treatment team believes there is a high level concern with my commitment to treatment, they will review my attendance history and there is a possibility for termination of services at EMCMHC. If services are terminated the EMCMHC staff will make and attempt to notify me in writing.

_____

Customer Signature Date

Eastern Montana Community Mental Health Center

Client Acknowledgement, Consent & Behavior

Please initial below to indicate you have received, read, and understood the following:

_____ Consent for Treatment

_____ Client Rights

_____ Grievance Procedure

_____ General Aggressive Behavior Policy

_____ Smoking and Weapons

_____ Notice of Privacy Practices

_____ No Show Policy

_____ For CSCT Clients Only – Coordination of Care Verification: "According to Administrative Rule (37.106.1956.4), Medicaid requires providers to inform youth and their parents about mandatory coordination expectations between CSCT, home support services, and outpatient therapy. I am aware that coordination is required among providers and collaboration is intended to improve outcomes for my child."

CLIENT SIGNATURE: _____

CLIENT PRINTED NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

PARENT/GUARDIAN PRINTED NAME: _____

STAFF SIGNATURE: _____

DATE: _____

Consent For Treatment

I consent to behavioral health treatment with EMCMHC for myself/minor child/designee.

I understand all clients of EMCMHC are eligible to receive a range of services addressing substance use disorders, mental health disorders, and medical issues (as applicable) on a limited basis.

The type and extent of services I/my child receive(s) will be determined through a collaborative treatment team effort and through discussion with me/my child in the development of an individualized treatment plan.

I understand a range of behavioral health professionals, some of whom are in training, provide EMCMHC services. Designated licensed staff provides oversight to all professionals in training.

I understand the various treatments offered provide significant benefits and may pose risks, which can be discussed with the treatment team. The process of behavioral health recovery may include relapse.

I understand some areas of EMCMHC campuses are under camera surveillance to address safety and security concerns.

I understand the success of treatment is dependent upon motivation to change with the therapeutic support of EMCMHC professional staff.

I understand if I am at least 16 years of age, I may consent to receive services from EMCMHC without parental consent.

Client Rights

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving behavioral health services at any EMCMHC facility.
2. You have the right to be treated without regard to physical or mental disability, unless such disability makes treatment afforded by the facility non-beneficial or hazardous. Treatment will reflect both your ability to benefit from services and others' treatment rights.
3. You have the right to practice your religion of choice, insofar as such practice does not infringe on the rights and treatment of others. You have the right to be excused from any religious practice.
4. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your behavioral health services. You have the right to a reasonable explanation, in terms you can understand, of your general condition; treatment objectives; the nature and significant possible adverse effects of recommended treatment; reasons this treatment is considered appropriate; and what, if any, alternative treatment services and types of behavioral health providers are appropriate and available.
5. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you, unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.
6. You have the right to confidential records. Although you must give written approval to allow your records to be released in most cases, there are some exceptions to this rule under state and federal law.
7. You have the right to request access to your records and the right to request corrections or amendments to your records. These and other privacy rights are explained more fully in EMCMHC's Notice of Privacy Practices.
8. You have the right to the maximum amount of privacy consistent with the effective delivery of services to you.
9. You have the right to appropriate treatment and related services under conditions that are supportive of your personal liberty.
10. You have the right to not be subjected to experimental research or other experimentation without your informed, voluntary, and written consent.
11. You have a right to be free from abuse and neglect, or threats of abuse and neglect, while receiving services at EMCMHC.
12. You have the right to a humane psychological and physical environment while receiving services at EMCMHC.
13. You have the right to receive information about EMCMHC's client grievance procedure and how to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate, available treatment. EMCMHC recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect, EMCMHC will provide a referral to a local client support group, a family member's support group, or a state designated advocacy agency.

14. You have the right to communication with family in emergency situations.
15. You have the right to receive services which reflect the awareness of the special needs of gender.
16. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and jail diversion programs and rights during an involuntary commitment process. A member of your treatment team will explain these rights to you if you have concerns.

Grievance Procedure

EMCMHC has established a grievance procedure for clients who believe their rights have been violated by the Center. If you feel your rights have been violated, please see any staff member to request a Grievance Form.

General Aggressive Behavior Policy

All EMCMHC Programs are designed to provide a safe place for our clients and staff. Aggressive behavior does not fit into this philosophy, and will not be tolerated at EMCMHC facilities, against EMCMHC staff, or other clients. Aggressive behavior is defined as yelling, pushing, physical fighting, throwing objects, swearing, or acting in a manner perceived to be threatening. If aggressive behavior occurs, EMCMHC will follow the following established policies and procedures.

STEP ONE: You/your child will be asked to leave the program/office for the day and you/your child will be referred to a member of your treatment team to address the aggressive behavior.
STEP TWO: You/your child will be asked to leave the program/office for one week. Prior to returning, you/your child will be required to meet with a member of your treatment team to develop a plan for adherence to the policy.
STEP THREE: You/your child will be asked to leave the program/office for 30 days. Prior to returning, you will be required to attend a treatment team meeting to evaluate appropriateness for continued participation in the program.

The Executive Director and/or Program Manager may exercise discretion in following this procedure to protect the safety of clients, staff, and the program. At any time, if behavior is deemed as causing imminent danger to yourself or others, authorities may be called to intervene.

NOTE: Due to the unique nature of 24 hour crisis programs, residential programs, detention centers, and CSCT programs additional policies will apply.

Smoking & Weapons

EMCMHC is invested in the health and well-being of clients and staff. All EMCMHC facilities are non-smoking which include all types of tobacco and e-cigarettes. No firearms or weapons are allowed at any EMCMHC facility.

No Show Policy

It is EMCMHC's goal to provide effective services as efficiently as possible. This cannot be done when individuals repeatedly miss appointments because they experience repeated crises, have repeated transportation failures, don't value the time with their service provider enough to make their appointments a priority, avoid services because they do not like the recommendations given, or they feel they can't afford our fees.
Whatever the reason, continuing to schedule appointments for individuals who repeatedly miss appointments is neither responsive to their situation nor an effective use of our resources. Below you will find the definitions of missed appointments.

No-Show/Late Cancellation - the family or client misses the appointment without notifying us, or notifies us less than 24 hours before their appointment.

Cancellation - the family or client notifies us at least 24 hours in advance that they will miss their appointment.

Please note after two consecutive no shows, two no show appointments in 90 days, or 3 cancellation over a 90 day period, the individual will not be scheduled for 30 days and will have to call EMCMHC and ask to see the service provider that day; if the service provider has no openings that day, the individual can call again on another day for a same-day appointment. If a client completes a session within 30 days, regular scheduling resumes.

If the client has not made contact with EMCMHC within 30 days the provider will assume the individual is no longer interested in services and will discharge the client.

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

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.

The confidentiality of mental health, alcohol and drug abuse patient records maintained by Eastern Montana Community Mental Health Center is protected by Federal law and regulations. Generally, Eastern Montana Community Mental Health Center may not say to a person outside Eastern Montana Community Mental Health Center that a patient attends Eastern Montana Community Mental Health Center, or disclose any information identifying a patient as a mental health, alcohol or drug abuser *unless:*

(1) You authorize the disclosure in writing;
(2) The disclosure is allowed by a court order; or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

WHO WILL FOLLOW THIS NOTICE

This notice describes Eastern Montana Community Mental Health Center's practices and that of:

- Any health care professional authorized to enter information into your treatment records.
- All departments and units of Eastern Montana Community Mental Health Center.
- All employees, staff and other Eastern Montana Community Mental Health Center personnel.
- All Eastern Montana Community Mental Health Center entities, sites and locations will follow the terms of this notice and may share health information with each other for treatment or operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We are committed to protecting health information about you. We create a record of the care and services you receive at Eastern Montana Community Mental Health Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Eastern Montana Community Mental Health Center. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, counselors, therapists, or other EMCMHC personnel who have a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment. For example, our counselors may share information about you with our psychiatrist if you have symptoms of depression or other mental disorder which may affect your recovery from chemical dependency. Likewise, our psychiatrist or medical doctor may share medical information about you with our staff in order to coordinate the different things you need, such as prescriptions or lab work.

For Health Care Operations. We may use and disclose health information about you for EMCMHC operations. These uses and disclosures are necessary to run EMCMHC and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many EMCMHC patients to evaluate trends in mental health and drug and alcohol use and to assess the effectiveness of our treatment services. We may also disclose information to doctors, nurses, technicians, therapists, and other EMCMHC personnel for review and learning purposes. We may also combine the health information we have with health information from other treatment centers to compare how we are doing and see where we can make improvements in the care and services we offer. We will remove the information that identifies you from this set of health information so others may use it to study treatment services without learning who the specific patients are.

Medical Emergencies. Medical information may be disclosed to medical personnel who have a need for information about you for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

Food and Drug Administration. Medical information may be disclosed to medical personnel of the Food and Drug Administration who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

Audit and Evaluation. Health information may be disclosed for the purpose of audit or evaluation by any federal, state, or local government agency which provides financial assistance to EMCMHC or is authorized by law to regulate our activities. Health information may also be disclosed for audit and evaluation purposes to a third party payer which covers our patients, to a peer review organization performing utilization or quality control review, or is determined by our program director to be qualified to conduct the audit or evaluation activities.

Child abuse or Neglect. We may report any information about suspected child abuse or neglect to appropriate state or local authorities.

Law Enforcement. We may disclose information about you to law enforcement officers concerning a crime committed on EMCMHC premises or against any person who works for EMCMHC or a threat to commit such a crime.

Vital Statistics. We may disclose information about you relating to cause of death under laws requiring the collection of death or vital statistics or permitting inquiry into the cause of death.

Subpoena and Court Order. If we receive a subpoena to disclose information about you, we will not do so unless a court of competent jurisdiction enters an authorizing order. A court order may authorize disclosure only if the court finds that the disclosure is necessary:

(1) to protect against an existing threat to life or of serious bodily injury;
(2) to investigate or prosecute an extremely serious crime; or
(3) in connection with litigation or an administrative proceeding in which you offer testimony or other evidence relating to the information.

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

1. Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include counselor's own notes (hand generated by the clinician). To inspect a copy of health information that may be used to make decisions about you, you must submit your request in writing to **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by EMCMHC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

2. Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by EMCMHC. To request an amendment, your request must be made in writing and submitted to: **EMCMHC, Administration, Box 1530, Miles City, Montana 59301.** In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

3. Right to an Accounting of Disclosures. You have the right to request an Accounting of Disclosures. This is a list of the disclosures we made of health information about you, other than disclosures to you or which you authorized. To request an Accounting of Disclosures, you must submit your request in writing to: **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. Your request must state a time period which may not be longer than seven years and may not include dates before April 14, 2003. The first Accounting of Disclosures you request within a 12 month period will be free. For additional requests, we may charge you for the costs of providing the Accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment or health care operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail. To request confidential communications, you must make your request in writing to **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact **EMCMHC, Administration, Box 1530, Miles City, Montana 59301** or call **406-234-0234.**

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at the Reception Desk at Eastern Montana Community Mental Health Center. The notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you are admitted to Eastern Montana Community Mental Health Center for treatment or health care services as an outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with EMCMHC or with the Secretary of the Department of Health and Human Services. To file a complaint with EMCMHC, contact our Privacy Officer, **Eastern Montana Community Mental Health Center, PO Box 1530, Miles City, Montana 59301**, phone number: **406-234-0234**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** Violation of the federal laws and regulations by EMCMHC is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

FEDERAL STATUTES AND REGULATIONS
This notice is issued pursuant to the following federal statutes and regulations:
Statutes: 42 U.S.C. 290dd-2
42 U.S.C. 1320d-1329d-8
42 U.S.C. 1320d-2
Regulations: 42 C.F.R. Part 2, 45 C.F.R. Subtitle A, Subchapter C, Part 160, Sections 160.101 – 164.534

If you have any questions about this notice, please contact the **Eastern Montana Community Mental Health Center, Administration, PO Box 1530, Miles City, Montana 59301**. Our phone number is **406-234-0234.**

Eastern Montana Community Mental Health Center

Grievance Form

TO: **Program Director**

FROM: _____ (name of person filing grievance).

ADDRESS: _____

TELEPHONE NUMBER: _____

I would like resolution on a possible violation of my rights at the Mental Health Center.

DATE OF INCIDENT(S): _____

SPECIIFIC RIGHTS VIOLATED: _____

_____

DESCRIBE INCIDENT(S) AND HOW RIGHTS WERE VIOLATED: _____

_____

_____

_____

_____

_____

_____

I DO or DO NOT (circle one) wish to have the assistance of a representative in filing this grievance. My representative will be _____.

(Representative's Name)

Signature: _____ Date: _____

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER

MEDICATION/ALLERGY LIST

Medication	Dosage	Frequency	Route Taken	Provider	Pharmacy

Allergy	Severity	Reaction

Eastern Montana Community Mental Health Center

Substance Use Screening

CAGE Ages 18 and over

1. Have you ever felt you should cut down or control your drug use or drinking?	□ YES □ NO
2. Have people annoyed you by criticizing your drug use or drinking?	□ YES □ NO
3. Have you ever felt bad or guilty about your drug use or drinking?	□ YES □ NO
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	□ YES □ NO

CRAFFT Ages 11-17

1. Have you ever ridden in a car driven by someone, including yourself, who was high or had been using alcohol or drugs?	□ YES □ NO
2. Do you ever use drugs or alcohol to relax, feel better about yourself, or to fit in?	□ YES □ NO
3. Do you ever use alcohol or drugs by yourself, alone?	□ YES □ NO
4. Do you ever forget things you did while using alcohol or drugs?	□ YES □ NO
5. Does your family or friends ever tell you that you should cut down on your drinking or drug use?	□ YES □ NO
6. Have you gotten into trouble while you were using alcohol or drugs?	□ YES □ NO

PRE-ADOLESCENT Ages 10 and under

1. Do you have any friends who have used alcohol or drugs of any kind in the past year?	□ YES □ NO
2. Have you ever had more than a few sips of alcohol or taken drugs of any kind in the past year? • If yes to alcohol, on how many days in the last year have you used alcohol? _____ • If yes to drugs, on how many days in the last year have you used drugs? _____	□ YES □ NO

WELLNESS SCREENING

1.	I have had experiences which have really affected my life.	_____	Yes	_____	No
2.	I worry a lot.	_____	Yes	_____	No
3.	Someone is really trying to make life hard for me.	_____	Yes	_____	No
4.	I have seen and heard things most people don't see or hear.	_____	Yes	_____	No
5.	I sometimes make myself vomit.	_____	Yes	_____	No
6.	I do not like myself.	_____	Yes	_____	No
7.	I can't think as clearly as I have in the past.	_____	Yes	_____	No
8.	I really feel sad a lot of the time.	_____	Yes	_____	No
9.	I can't get to sleep or stay asleep.	_____	Yes	_____	No
10.	I don't feel anything.	_____	Yes	_____	No
11.	I've been in trouble a lot.	_____	Yes	_____	No
12.	I feel guilty.	_____	Yes	_____	No
13.	I have a lot of physical problems.	_____	Yes	_____	No
14.	At times my thoughts have raced ahead faster than I could speak them, even when I am not using drugs	_____	Yes	_____	No
15.	I've had periods when I've felt so full of pep that sleep did not seem necessary for days at a time, even when I was not using drugs.	_____	Yes	_____	No
16.	I feel angry a lot of the time.	_____	Yes	_____	No
17.	Sometimes I think I am losing control or going crazy.	_____	Yes	_____	No
18.	My interest in food has really changed.	_____	Yes	_____	No
19.	I can't seem to make decisions or get things done.	_____	Yes	_____	No
20.	Sometimes I wish I could do better with my life	_____	Yes	_____	No
21.	I think of harming or killing myself.	_____	Yes	_____	No
22.	I have hurt myself on purpose.	_____	Yes	_____	No
23.	I think of hurting others.	_____	Yes	_____	No
24.	Life is good.	_____	Yes	_____	No

Name:_____ Date: _____

Behaviors and Symptoms

Reason for Seeking Treatment: *Please describe the situation or problem that led you to this Center*

_____

_____

_____

Life Stressors:

- ☐ Job Loss
- ☐ Relationship Breakup
- ☐ Military Deployment (combat or support)
- ☐ Sexual/Physical Assault Victim
- ☐ Court Ordered
- ☐ Substance Use Issues
- ☐ Other (Please explain)

_____

_____

Referred By:

Check all that apply to you AT THE PRESENT TIME

_____ Appetite Problem

_____ Sleep Problem

_____ Feel Stressed

_____ Depressed Mood

_____ Guilt Feelings

_____ Thinking About Harming Self Today _____ Within Last 2 Weeks _____

_____ Thinking About Harming Others Today _____ Within Last 2 Weeks _____

_____ Difficulty Maintaining Friendships

_____ Difficulty Making Decisions

_____ Experience Upsetting Thoughts That Will Not Go Away

_____ Sexual Problems

_____ Self-esteem Issues

_____ Difficulty Concentrating

_____ Frequent Temper Loss

_____ Bored Most of the Time

_____ Other

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

FRONTIER
PSYCHIATRY

Consent to Psychiatric Treatment by Frontier Psychiatry, LLC

I am signing this consent for psychiatric assessment and treatment on behalf of...

❑ MYSELF ❑ A MINOR ❑ A DEPENDENT ADULT

1. Benefits of Psychiatric Treatment
    a. Frontier Psychiatry will provide me with a psychiatric assessment, diagnosis and treatment services that, at a minimum, meet Montana's standard of care;
    b. When indicated, Frontier Psychiatry providers may provide both psychotherapy (aka "talk therapy") and medication management services;
    c. When possible, Frontier Psychiatry providers will coordinate psychiatric care with my community based counselor or therapist;
    d. Frontier Psychiatry providers may refer me to other medical, behavioral, or allied health professionals as needed to support an approach to holistic and comprehensive care.
2. Risks of Psychiatric Treatment
    a. Medications or supplements that have been prescribed or recommended by Frontier Psychiatry may cause physical or behavioral side effects;
    b. Engaging in psychotherapy may involve discussing unpleasant aspects of my life and can, at times, cause feelings of distress (eg. guilt, anxiety, frustration). While these experiences are generally temporary, it is extremely important that I describe them to my psychiatric provider.
3. Alternatives to Psychiatric Treatment
    a. I have the freedom to accept or reject treatment recommendations made by Frontier Psychiatry;
    b. I have the option to seek a second opinion regarding the diagnostic and treatment recommendations made by Frontier Psychiatry;
    c. I may end the treatment relationship with Frontier Psychiatry at any time.
4. Communication with Frontier Psychiatry
    a. Frontier Psychiatry will attempt to be available for urgent issues by phone; however, in the case of an emergency, I will call 911 immediately. I also know that I can reach the National Suicide Prevention Hotline at 1-800-273-8255 or I can reach the Crisis Text Line at 741-741.
    b. I understand that email should never be used for urgent or emergency issues. It is not a confidential means of communication and the email messages may not be received or answered in a timely fashion.
5. Payment
    a. Frontier Psychiatry is enrolled with several major public and private insurers in Montana. I am responsible for payment if my insurance policy has lapsed or I have neglected to keep the policy current. I am also responsible for any co-pays associated with treatment;

b. I hereby assign any of my health insurance benefits to be paid directly to Frontier Psychiatry;
c. Please find the self-pay rates - $400 for a New Patient Appointment, $200 for an Established Patient Appointment;
d. I understand that if I no-show my appointment I will be charged $25;
e. I understand that if my insurance is out-of-network and not accepted by Frontier Psychiatry that I will be considered self pay.

6. No Show Policy
   a. 1st no show - waived;
   b. 2nd no show - $25 dollar fee;
   c. 3rd no show - no further patient appointments will be scheduled.
7. Secure Telehealth Services
   a. I consent to receive the services described above via telehealth, as may be necessary or appropriate under the circumstances;
   b. Telehealth involves the use of electronic communications, such as real time audio, video, and data communications, to enable health care providers at different locations to share an individual's health information to diagnose, consult and/or treat the individual. Electronic communications used for telehealth incorporate network and software security protocols to protect the privacy and security of patient health information.
   c. As with any health care service, there are expected benefits and possible risks involving the use of telehealth. The expected benefits associated with the use of telehealth include, without limitation, improved access to health care and the ability to obtain the expertise of providers and specialists not readily available in the geographic area.
   d. Possible risks associated with telehealth include: potential delays in evaluation or treatment due to technical difficulties with equipment; information being transmitted in insufficient form to allow for a complete medical examination by the distant site practitioner; information may be lost during transmission due to technical failures; and despite security protocols being in place, the privacy of patient health information may be compromised when transmitted electronically.
   e. I have the right to withhold or withdraw my consent to the use of telehealth without affecting my right to future care or treatment. By signing in the space below, I consent to receive services via telehealth.

Name of patient (print):
Name of legal guardian (print): **Only if patient is under 18 or a dependent adult*

Signature of patient and guardian:	Date:

FRONTIER
PSYCHIATRY

Authorization for Release of Protected Health Information

Today's Date:	**Legal Name:**
Date of Birth:	**Address:**
Phone Number:	

As a Frontier Psychiatry patient, I understand that state and federal regulations govern the confidentiality and protection of identifiable health information (CFR 42 Part 2, CRS 25.1, HIPAA). Except in situations legally required or permitted, information about me cannot be disclosed to persons or agencies outside of Frontier Psychiatry without my written permission. I understand that additional protections exist for substance abuse information and for HIV/AIDS information.

I consent to release the following types of information listed: (please mark all that apply)

☐ Psychiatric Evaluation	☐ Medication Management/Progress Notes
☐ Social History/Background	☐ Psychological/Neurological Testing
☐ Medical/Lab Information	☐ All Substance Use Information
☐ Update and/or Discharge Summaries	☐ Diagnostic Assessments
☐ Legal Information	☐ Billing/Payment History
☐ HIV/AIDS Information	☐ Other:

I hereby authorize Frontier Psychiatry to send, receive, exchange, use or disclose health information about me to:

One (1) form per authorization is required.

Facility:	**Contact Name:**
Address:	**City/State:**
Phone Number:	**Fax Number:**

Authorization:

I understand that the information to be released might include information regarding treatment of mental health, alcohol and drug usage, HIV and AIDS related information.

Re-disclosure:

I understand that information disclosed based on this Authorization, except for information about a substance use

disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

Prohibition on Conditioning of Authorizations:

I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. Frontier Psychiatry may not refuse to treat me if I refuse to sign this Authorization.

Expiration and Right to Revoke (Cancel):

I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire in one year from the date I sign it unless an earlier date is specified here

Expiration Date:

Client or Representative Signature If Representative, Relationship to Client Witness

Printed Name:
Signature:

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

I hereby request and authorize

Eastern Montana Community Mental Health Center | PO Box 1530, Miles City, MT 59301 | 406-234-1687 | 406-234-1698

Name of Individual/Organization | Address | Phone | Fax

TO RELEASE TO: _____ Client Initials **OBTAIN FROM:** _____ Client Initials **EXCHANGE WITH:** _____ Client Initials

_____

Name of Individual/Organization | Address | Phone | Fax

The type and amount of information to be used or disclosed is as follows: (provide a specific and meaningful description of the information, including dates where appropriate)

_____Discharge Summary
_____Progress Notes
_____Master Treatment Plan
_____Educational Records
_____Psychological Testing
_____Medical Records/Reports
_____Other: _____

_____Psychological/Mental Status Assess.
_____Medical Assessment
_____Psychiatric Evaluation
_____Medication Update
_____Biopsychosocial Evaluations
_____Billing and Insurance processes

_____Social History
_____Treatment Issues
_____Referral For Med
_____Hospital Records

PLEASE NOTE: the client (and parent/personal representative, if applicable) must initial here _____ to authorize disclosure of records of alcohol/drug evaluation and treatment.

I have the right to inspect and copy any information being disclosed.

I understand I may revoke this authorization in writing at any time except for the extent that action has already been taken on this authorization.

This authorization will expire on the following date or event: _____

Date | Patient Initials

If I fail to specify a date or event, it will expire in six months.

I understand that I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may no longer be protected by federal confidentiality rules.

I have received a copy of this authorization.

_____ _____

Signature of Patient **Date** **Signature of Witness** **Date**

_____

Signature of Parent/Personal Representative **Date**

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: If 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 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.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

I hereby request and authorize

_____
Name of Individual/Organization Address Phone Fax

TO RELEASE TO: _____ **OBTAIN FROM:** _____ **EXCHANGE WITH:** _____
Client Initials Client Initials Client Initials

_____
Name of Individual/Organization Address Phone Fax

The type and amount of information to be used or disclosed is as follows: (provide a specific and meaningful description of the information, including dates where appropriate)

_____Discharge Summary	_____Psychological/Mental Status Assess.	_____Social History
_____Progress Notes	_____Medical Assessment	_____Treatment Issues
_____Master Treatment Plan	_____Psychiatric Evaluation	_____Referral For Med
_____Educational Records	_____Medication Update	_____Hospital Records
_____Psychological Testing	_____Biopsychosocial Evaluations	
_____Medical Records/Reports	_____Billing and Insurance processes	

_____Other: _____

PLEASE NOTE: the client (and parent/personal representative, if applicable) must initial here _____ to authorize disclosure of records of alcohol/drug evaluation and treatment.

I have the right to inspect and copy any information being disclosed.

I understand I may revoke this authorization in writing at any time except for the extent that action has already been taken on this authorization.

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Date Patient Initials

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I have received a copy of this authorization.

_____ _____
Signature of Patient **Date** **Signature of Witness** **Date**

_____
Signature of Parent/Personal Representative **Date**

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: If 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 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.