Chemical Dependency – Adult Intake Checklist:

Fill out the following forms before your Evaluation appointment. Please arrive 10 minutes before your appointment to apply your insurance.

☐ Demographic Entry I
☐ Release of Information – Insurance Company
☐ GCBH Release of Confidential Information
☐ GAINS Form
☐ Notice of Rights - Medicade
☐ Notice of Rights - Non - Medicade
☐ Application for Services/Consent to Services/Acknowledge of Notice of Privacy
☐ Patient Perspective Checklist Fee Policy & Agreement
☐ TB Risk screen
☐ Risk Self Assessment
☐ HIV Risk Chain

<u>Additional Reading Material</u>
HIPPA Letter
HIPPA Privacy Practices
Tuberculosis Pamphlet
Chemical Dependency Staff

PALOUSE RIVER COUNSELING

Demographics Entry I

THIS SECTION - OFFICE USE ONLY

Consumer ID: _____ Date of First Contact: _____

First Scheduled Intake Date: _____ Admit Date: _____ Case Manager ID: _____

MIS Entry Date _____ Entered by _____(Initials)

CONSUMER COMPLETES

Legal Name _____
Last First Middle

Address (Mailing) _____ **Home Phone #** _____

(Residence, If Different)_____ **Work Phone #** _____

_____ **Message #** _____
City State Zip (include +4 code if known)

Gender: ☐**(1)** Female ☐**(2)** Male ☐**(3)** Unknown **Birthdate**_____ **Soc. Sec. No.**_____-_____-_____
Mo./Day/Yr.

Sexual Orientation: ☐**(1)** Heterosexual ☐**(3)** Gay or Lesbian ☐**(4)** Bisexual ☐(5) Person states they are questioning

☐**(9)** Decline to Respond, Unknown, or Age 0-12

Ethnicity (select *up to 4* codes to indicate what race you consider yourself to be):

- ☐ **(010)** Caucasian/White
- ☐ **(021)** American Indian/Alaska Native
- ☐ **(031)** Asian Indian
- ☐ **(032)** Native Hawaiian
- ☐ **(033)** Other Pacific Islander
- ☐ **(034)** Other Asian
- ☐ **(040)** Black/African American
- ☐ **(050)** Some Other Race
- ☐ **(605)** Chinese
- ☐ **(608)** Filipino
- ☐ **(611)** Japanese
- ☐ **(612)** Korean
- ☐ **(619)** Vietnamese
- ☐ **(655)** Samoan
- ☐ **(660)** Guamanian/Chamorro

Hispanic Origin:

- ☐ **(998)** Not Spanish/Hispanic
- ☐ **(727)** Puerto Rican
- ☐ **(722)** Mexican/Mexican-American/Chicano
- ☐ **(799)** Other Spanish/Hispanic
- ☐ **(709)** Cuban

Preferred Language (please indicate the language in which you prefer to receive services):

☐ **(13)** English ☐ **(03)** Spanish ☐ Other Language(s): _____

Completed by – Name: _____ **Date:** _____

Palouse River Counseling
340 N.E. Maple St, Pullman, WA 99163 (509) 334-1133

INSURANCE COMPANY / POLICY HOLDER
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ of _____

_____

_____
(Address)

authorize Palouse River Counseling to mutually exchange with:

_____
(Name of the person or organization to which disclosure is to be made)

the following information: **Diagnosis, Chart Notes, Dates of Service, Demographic Information, Discharge Summary, Assessments and Evaluations, ASAM Level of Care ___**

_____

_____

Purpose: **Receive payment for services rendered.**_____
_____

_____

I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for under part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of drug and alcohol treatment records. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires automatically as described below.

Specification of the date, event, or condition upon which this consent expires:

90 Days from date of discharge

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Executed this _____ day of _____, 20___.

_____ _____
(Signature of participant) (Signature of parent/guardian if client is under 14 y.o.)

NOTICE

PROHIBITING REDISCLOSURE

OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Redisclosure
of

Confidential Information

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

Consent for Release of Confidential Information

I, _____, authorize
(Name of Patient)

Palouse River Counseling
(Name or general designation of alcohol/drug program making disclosure)

to disclose to **Greater Columbia Behavioral Health BHO**
(Name of person or organization to which disclosure is to be made)

the following information: **Identifying information, admission date, initial clinical assessment, program specific mental health and/or substance use disorder assessment, individual service plan, service encounters, anticipated discharge date, and discharge information if applicable.**

(Nature and amount of the information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this is to: **Support coordination of care, payment, and health care operations**.

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

No more than 13 Months from the date below.
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
I have been provided a copy of this form.

Dated: _____

_____
Signature of Patient

_____
Signature of person signing form if not patient

Describe authority to sign on behalf of patient_____

Washington State Department of Social & Health Services

Mental Health Division

PALOUSE RIVER COUNSELING

GAIN-SS FORM

Section Completed by Clinician
Intake/Admission [ ] Tx Plan Session [ ] Crisis Episode [ ]
Declined [ ] Unable to complete [ ]

Staff ID	RU	Location	SAC	Dur	Start Time	Refer/LOF
			5063 GAIN-SS	5 min	: am /pm	
			5064 Co-Occurring Assess	5 min	: am /pm	

Demographic Information and GAIN-SS (Self-Report) Complete by Consumer					
DATE	LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	GENDER ☐ Male ☐ Female

By answering the questions in this checklist, you will help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community.

Completing the checklist is optional. If you are willing to answer the questions, please complete the survey and sign your name at the bottom of this page. If you do not wish to answer the questions, please tell your treatment provider and give the checklist back to your treatment provider.

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions Yes or No.

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

During the past 12 months, have you had significant problems. . .		
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	☐ Yes	☐ No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	☐ Yes	☐ No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	☐ Yes	☐ No
d. when something reminded you of the past, you became very distressed and upset?	☐ Yes	☐ No
e. with thinking about ending your life or committing suicide?	☐ Yes	☐ No

IDS Sub-scale Total (0 to 5)_____

During the past 12 months, did you do the following things two or more times?		
a. Lie or con to get things you wanted or to avoid having to do something?	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home?	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home?	☐ Yes	☐ No
d. Been a bully or threatened other people?	☐ Yes	☐ No
e. Start fights with other people?	☐ Yes	☐ No

EDS Sub-scale Total (0 to 5)_____

During the past 12 months did. . .		
a. you use alcohol or drugs weekly?	☐ Yes	☐ No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	☐ Yes	☐ No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	☐ Yes	☐ No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	☐ Yes	☐ No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	☐ Yes	☐ No

SDS Sub-scale Total (0 to 5)_____

Client Signature : _____ Date _____

OFFICE USE ONLY

List the scores from the front of the GAINS in these areas:

_____ IDS score
_____ EDS score
_____ SDS score

NOTE: A score of 2 or more in any one of the 3 sections indicates a positive screen and should be addressed in the next section of Quadrant placement.

Quadrant Placement

☐ 9 – no quadrant placement needed, service will be provided by:

- ☐ No Service Recommended – No score more than 2 on IDS, EDS, or SDS.
- ☐ Recommend CD Evaluation – Score only on SDS 2 or more.
- ☐ Recommend MH Request for Service / Intake – Scored 2 or more on IDS, SDS or both IDS and EDS.

☐ 1 – Quadrant 1: Less Severe Mental Health and Less Severe Chemical Dependency Placement.

☐ 2 – Quadrant II: More Severe Mental Health and Less Severe Chemical Dependency Placement.

☐ 3 – Quadrant III: More Severe Chemical Dependency and Less Severe Mental Health Placement.

☐ 4 – Quadrant IV: More Severe Chemical Dependency and More Severe Mental Health Placement.

If test indicates a quadrant placement explain why if No Quadrant Placement is chosen:

_____
_____
_____

If Quadrant Score is given please list recommendations for service for this decision:

_____
_____
_____

Please list referrals made at this point and contact information:

_____
_____
_____

_____ _____

Name of Screener Date

Palouse River Counseling

NOTICE OF RIGHTS – MEDICAID RECIPIENTS

PRC supports the belief that each of our consumers deserves the highest quality of medical and psychological care we are able to provide. In addition, it is appropriate that all consumers be notified of these right's while being served. Your signature indicates that you agree to accept treatment under these conditions, and that you are aware of your rights.

WAC 388-877-0680—Individual Rights specific to Medicaid recipients.

Medicaid recipients have general individual rights and Medicaid-specific rights when applying for, eligible for, or receiving behavioral health services authorized by a behavioral health organization (BHO).

A. General rights that apply to all individuals, regardless of whether an individual is or is not a Medicaid recipient, include:

1. All applicable statutory and constitutional rights;
2. The participant rights provided under WAC 388-877-0600; and
3. Applicable necessary supplemental accommodation services in chapter 388-472 WAC.

B. Medicaid-specific rights that apply specifically to Medicaid recipients include the following. You have the right to:

1. Receive medically necessary behavioral health services, consistent with access to care standards adopted by the department in its managed care waiver with the federal government. Access to care standards provide minimum standards and eligibility criteria for behavioral health services and are available on the behavioral health administration's (BHA) division of behavioral health and recovery (DBHR) website.
2. Receive the name, address, telephone number, and any languages offered other than English, of behavioral health providers in your BHO.
3. Receive information about the structure and operation of the BHO.
4. Receive emergency or urgent care or crisis services.
5. Receive post-stabilization services after you receive emergency or urgent care or crisis services that result in admission to a hospital.
6. Receive age and culturally appropriate services.
7. Be provided a certified interpreter and translated material at no cost to you.
8. Receive information you request and help in the language or format of your choice.
9. Have available treatment options and alternatives explained to you.
10. Refuse any proposed treatment.
11. Receive care that does not discriminate against you.
12. Be free of any sexual exploitation or harassment.
13. Receive an explanation of all medications prescribed and possible side effects.
14. Make a mental health advance directive that states your choices and preferences for mental health care.
15. Receive information about medical advance directives.
16. Choose a behavioral health care provider for yourself and your child, if your child is under thirteen years of age.
17. Change behavioral health care providers at any time for any reason.
18. Request and receive a copy of your medical or behavioral health services records, and be told the cost for copying.
19. Be free from retaliation.
20. Request and receive policies and procedures of the BHO and behavioral health agency as they relate to your rights.
21. Receive the amount and duration of services you need.
22. Receive services in a barrier-free (accessible) location.
23. Medically necessary services in accordance with the early periodic screen, diagnosis and treatment (EPSDT) under WAC 182-534-0100, if you are twenty years of age or younger.
24. Receive enrollment notices, informational materials, materials related to grievances, appeals, and administrative hearings, and instructional materials relating to services provided by the BHO, in an easily understood format and non-English language that you prefer.

25. Be treated with dignity, privacy and respect, and to receive treatment options and alternatives in a manner that is appropriate to your condition.
26. Participate in treatment decisions, including the right to refuse treatment.
27. Be free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.
28. A second opinion from a qualified professional within your BHO area at no cost, or to have one arranged outside the network at no cost to you, as provided in 42 C.F.R. § 438.206(3).
29. Receive medically necessary behavioral health services outside of the BHO if those services cannot be provided adequately and timely within the BHO.
30. File a grievance with the BHO if you are not satisfied with a service.
31 Receive a notice of action so that you may appeal any decision by the BHO that denies or limits authorization of a requested service, that reduces, suspends, or terminates a previously authorized service, or that denies payment for a service, in whole or in part.
32. File an appeal if the BHO fails to provide services in a timely manner as defined by the state, or act within the timeframes provided in 42 CFR § 438.408(b).
33. Request an administrative (fair) hearing if your grievance or appeal is not resolved in your favor.
34. Services by the behavioral health ombuds office to help you in filing a grievance or appeal, or to request an administrative hearing.

A behavioral health agency licensed by the division of behavioral health and recovery (DBHR) and certified by DBHR to provide mental health and/or substance use disorder services must ensure the Medicaid rights described in subsection (1)(b) of this section are:

A. Provided in writing to each Medicaid recipient, and if appropriate, the recipient's legal representative, on or before admission;
B. Upon request, given to the Medicaid recipient in an alternative format or language appropriate to the recipient and, if appropriate, the recipient's legal representative;
C. Translated to the most commonly used languages in the agency's service area; and
D. Posted in public areas.

YOU HAVE THE RESPOSIBILITY TO:

- Provide the information needed for your care.
- Understand your behavioral health.
- Follow the plans for care that you have agreed to with your doctor, nurse, therapist, and/or case manager.

MINORS (UNDER THE AGE OF 18) MAY BE TREATED UNDER THE FOLLOWING CONDITIONS:

A. Any minor 13 years or older may request and receive mental health treatment upon his or her own request without the consent of his or her parent or legal guardian.
B. Any minor 13 years or older may receive mental health services upon request of his or her parent or legal guardian. Such a request must be accompanied by written consent knowingly and voluntarily given by the minor.
C. Applications for voluntary treatment made by persons under 13 years of age shall be accompanied by a written consent of the parent or legally responsible person unless the child is referred by child protective services or other public agency because of physical, sexual or psychological abuse or neglect by a parent or parent surrogate.

All of these rights comply with WAC (Washington Administrative Code) WAC 388-877-0680.

My signature indicates that I am aware of my rights and acknowledge that I have received a copy of these rights.

Consumer Signature _____ Date _____

Palouse River Counseling

NOTICE OF RIGHTS – ALL CLIENTS

PRC supports the belief that each of our consumers deserves the highest quality of medical and psychological care we are able to provide. In addition, it is appropriate that all consumers be notified of these right's while being served. Your signature indicates that you agree to accept treatment under these conditions, and that you are aware of your rights.

WAC 388-877-0600—Individual Rights.

Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 70.96A, 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:

A. Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
B. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
C. Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
D. Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
E. Be free of any sexual harassment;
F. Be free of exploitation, including physical and financial exploitation;
G. Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
H. Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
I. Receive a copy of agency grievance system procedures upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and
J. Lodge a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.

Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:

A. Provided in writing to each individual on or before admission;
B. Available in alternative formats for individuals who are blind;
C. Translated to the most commonly used languages in the agency's service area;
D. Posted in public areas; and
E. Available to any participant upon request.

Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.

In addition to the requirements in this section, each agency providing services to Medicaid recipients must ensure an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their Medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.

The grievance system rules in WAC 388-877-0654 through WAC 388-877-0675 apply to an individual who receives behavioral health services funded through a federal Medicaid program or sources other than a federal Medicaid program.

YOU HAVE THE RESPOSIBILITY TO:

- Provide the information needed for your care.
- Understand your behavioral health.
- Follow the plans for care that you have agreed to with your doctor, nurse, therapist, and/or case manager.

MINORS (UNDER THE AGE OF 18) MAY BE TREATED UNDER THE FOLLOWING CONDITIONS:

A. Any minor 13 years or older may request and receive mental health treatment upon his or her own request without the consent of his or her parent or legal guardian.
B. Any minor 13 years or older may receive mental health services upon request of his or her parent or legal guardian. Such a request must be accompanied by written consent knowingly and voluntarily given by the minor.
C. Applications for voluntary treatment made by persons under 13 years of age shall be accompanied by a written consent of the parent or legally responsible person unless the child is referred by child protective services or other public agency because of physical, sexual or psychological abuse or neglect by a parent or parent surrogate.

All of these rights comply with WAC (Washington Administrative Code) WAC 388-877-0680.

My signature indicates that I am aware of my rights and acknowledge that I have received a copy of these rights.

_____ _____

Consumer Signature Date

Palouse River Counseling
Chemical Dependency Adult/Youth

Application for Services
Consent to Services
Advocacy / Referral List
Advance Directive Attestation
Acknowledgement of Notice of Privacy Practices

Application for Services:

I do hereby request psychological and/or psychiatric services from Palouse River Counseling (PRC) for myself or _____, who is legally in my care. I understand that this formal request for services is for licensed and/or certified care under WAC 388-865 which details the types and manner of treatment I may receive. This request is made completely voluntarily and in no way limits my ability to seek help for myself from other medical services, social care agencies, private sector providers or natural care givers. I understand that I am strongly encouraged to seek a medical checkup if I have not done so recently.

Consent to Services *(Authorization)*:

I do hereby consent and authorize Palouse River Counseling to provide any appropriate licensed and/or certified care under WAC 388-865 as may be determined to be needed for my treatment. I acknowledge my right and responsibility to participate in the development, individualized treatment plan and to approve and sign it prior to standard outpatient and/or medication therapy.

This application for services and consent/authorization for treatment shall expire upon termination of my treatment and formal closure of my file.

Advocacy / Referral List:

I acknowledge receipt of the local Advocacy Group and Referral List.

Advance Directive Attestation:

* I have received an explanation about the Washington State Advance Directive.
* I understand the information that was provided to me and that I have had adequate opportunity to ask questions about the Advance Directive.

Acknowledgement of Notice of Privacy Practices:

I have received and had the opportunity to read the Notice of Privacy Practices given to me by Palouse River Counseling.

By signing this document, I am verifying the above.

_____ _____
Consumer Signature / Legal Guardian Date

_____ _____
PRC Representative / Counselor Date

Palouse River Counseling Center
Patient Perspective Checklist

I have trouble staying clean and/or sober when…	Yes	No	Unsure
…when my friends are using around me	☐	☐	☐
…when I feel lonely	☐	☐	☐
…when I feel angry	☐	☐	☐
…when I feel ashamed	☐	☐	☐
…when I'm in physical pain	☐	☐	☐
…when I'm in emotional pain	☐	☐	☐
… when I'm bored	☐	☐	☐
… when I have an argument with someone	☐	☐	☐
… when someone is angry or disappointed at me	☐	☐	☐
… when I just feel like giving up	☐	☐	☐
… when I want to punish someone important to me	☐	☐	☐
… when I feel shy around other people	☐	☐	☐
… when I'm stressed out	☐	☐	☐
… when I'm not taking good care of myself	☐	☐	☐
… when I feel guilty	☐	☐	☐
… when withdrawal symptoms become too uncomfortable	☐	☐	☐
… when I see no purpose to my life	☐	☐	☐
… when I feel that I have never really succeeded at anything	☐	☐	☐
… when I feel happy	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

Additional thoughts about situations that make it harder for you not to use:

_____

_____

_____

What do you see as your biggest barrier to living a clean and sober life? _____

_____

_____

Patient name Signature Date

Reviewed by CDP/CDPT _____ Date _____

Palouse River Counseling
Fee Policy & Fee Agreement

Palouse River Counseling (hereafter as PRC) accepts Medicaid, Medicare, and a variety of insurance. This agreement covers your intake/evaluation and any subsequent services.

Medicaid, Medicare, or Insurance:

PRC requires that you bring in proof of insurance at the time of your intake/evaluation. We will bill your insurance for services at the established rate. **Co-pays must be paid at the time of service, as required by your insurance company.** If your insurance does not pay the contracted amount, you will be responsible for the amount not paid. It is up to the policy holder of the insurance to know what their insurance covers. PRC may assist in verifying coverage, but cannot guarantee payment. Therefore all financial obligations are still you or your dependent's responsibility. **You are responsible for notifying PRC of any change and or termination to your coverage**. Should your coverage change or terminate, or if the services are denied by the insurance company, you are responsible for paying for the services you or your dependent receives. You are responsible for obtaining all initial and on-going referrals/authorizations prior to receiving services.

Clients without Insurance Coverage or Clients Choosing Not to Use Insurance:

If you do not have Medicaid, Medicare, or Insurance, you will be responsible for paying for services rendered at the fee established for you. PRC does offer a sliding fee scale on a limited basis. Please ask at the front desk to find out if you qualify for this funding source. PRC may have the ability to arrange a payment plan to help with the cost of services. If you are on a payment plan you are required to keep the plan current.

Non-Insurance 3rd Party Coverage:

If another source, other than those mentioned above, will be paying for your services, you are responsible for obtaining the appropriate referrals/authorizations prior to receiving services. If referrals/authorizations are not received you will be responsible for payment of services.

Collection, Administrative Fee and No-Show/Late Cancellation Fees:

PRC will charge $40.00 for no-show/late cancellation appointments. We ask that you cancel or re-schedule appointments as far in advance as possible but give at least 24 hour notice to avoid a $40.00 charge. PRC reserves the right to use Chapman Financial Services as the collection agency to collect overdue balances. PRC will charge $30.00 for checks returned for NSF.

Billing Information:

This agreement is re-negotiable with loss or changes to Medicaid, Medicare, or Insurance. You will receive a monthly billing statement from PRC. Payment is due within 30 days of receiving the statement. We accept cash, check, VISA, MasterCard, and Discover. Payments over the phone are also accepted.

I acknowledge that the information provided to PRC regarding my coverage is true and accurate. I agree to pay the established fees as indicated on the back of this agreement. I also authorize this agency to release any information necessary to process my Medicaid, Medicare, or Insurance claim(s). I further acknowledge that this information has been reviewed with me and that I have received a copy.

Client Printed Name: _____ Date: _____

Client Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PRC Representative: _____ Date: _____

The following are the fees charged at Palouse River Counseling (PRC) for Mental Health and/or Chemical Dependency Services.

Alcohol and Drug Information School	125.00	
Day Support (Harvest House)	25.00	/Hour
Evaluation (Chemical Dependency)	120.00	(half of fee is required at time of evaluation)
Evaluation (Mental Health)		
Standard	150.00	(half of fee is required at time of evaluation)
Intensive	200.00	(half of fee is required at time of evaluation)
Evaluation (Medical)	250.00	
Group (Per Group)	54.00	
Individual (Chemical Dependency)	120.00	
Individual (Mental Health)		
Standard	120.00	
Intensive	150.00	
Information and Referral	0.00	
Intensive Outpatient Program	2,800.00	
Medication Management	50.00 - 185.00	
Psychological Testing	TBD	
Urinalysis Collection	120.00	
Urinalysis Lab	Variable	

*All fees are subject to change.

March 1, 2018

Palouse River Counseling TB History and Risk Assessment/Sympton Screen

TB History:

1) Have you ever tested positive for TB infection? o No o Yes

2) Have you ever been diagnosed with having TB disease? o No o Yes

3) If you answered yes to question 1 or 2 did you complete treatment? o No o Yes

Please list where you completed treatment: _____

Risk Assessment:

1) Have you ever worked or lived with or spent time where or been exposed to anyone who has been set with TB in the last two years? o No o Yes

2) Have you lived or traveled to Africa, Western Europe, Russia, Mexico, Central or South America, Asia, India, or the Philippines? o No o Yes

3) Have you ever lived in a correctional facility, long-term care facility, or homeless shelter? o No o Yes

4) Have you ever injected illegal drugs? o No o Yes

5) Do you smoke? o No o Yes

⇨ If you answered yes to any of the above risk assessment questions please turn this page over and complete the Symptom Screen.

_____ _____

Signature Date

Symptom Screen

Please check yes or no to any of the following symptoms:

1) Drenching night sweats of more than two weeks in duration o No o Yes

2) Unexplained weight loss o No o Yes

3) Body weight 10% below ideal body weight o No o Yes

4) Loss of appetite o No o Yes

5) A cough lasting more than two weeks o No o Yes

6) Coughing or spitting up blood o No o Yes

7) Hoarseness; and/or chest pain o No o Yes

⇨ If you answered yes to any of the above symptoms screening questions please inform your counselor and you will be referred to your primary care provider, private clinic, or Health Department for immediate TB testing, medical evaluation, treatment and documentation or a noninfectious state, prior to admission.

Palouse River Counseling

Chemical Dependency Staff

Mark J. Ziegler, MSW, CDP, Adult & Youth Counselor, Clinical Director: CP00002260
Education and Experience:

Chemical Dependency Professional
Master in Social Work, Boise State University
Bachelor of Science in Psychology, Washington State University
ADIS Certified

Kimberly Thompson, CDP, Adult Counselor CP00005783
Education and Experience:

Chemical Dependency Professional
Bachelor of Science in Psychology with emphasis on Clinical Helping Skills
Minors in Sociology and Alcohol Studies and Other Drug Studies
Chemical Dependency Certification at Washington State University

Peter Vandersteen, CDP, MA, Adult Counselor CP60499021
Education and Experience:

Chemical Dependency Professional
Master in Addiction Studies, Hazelden Graduate School

Palouse River Counseling

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A Pullman United Way and Colfax Community Fund Agency

March 13, 2017

Dear Sir or Madam:

This notice is being provided to everyone who is currently receiving care from our agency. There are federal regulations, called the Health Insurance Portability and Accountability Act (HIPAA), that are intended to safeguard your healthcare information.

Palouse River Counseling is providing a Notice of Privacy Practices to all persons receiving services at our agency. This is intended to inform you of how our agency will safeguard your personal healthcare information currently on file.

Please sign the acknowledgement page at the back of this packet and return it to the receptionist or your counselor. Please note for clients age 13-17 we need signature(s) of the client. The client's parent/guardian may also sign in desired.

If you have any questions regarding this notice, please feel free to speak with your counselor or contact our Privacy Officer.

Thank you for your cooperation.

Sincerely,

Mike Berney

Mike Berney
Executive Director

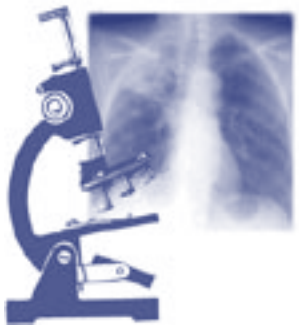
enclosures

test to react as positive. The test may also be falsely negative if your immune system is not working properly.

A negative QFT usually means you are not infected.

What if the test is positive?

A positive skin test or QFT usually means that you have been infected with the TB germ. It does not necessarily mean that you have TB disease. Other tests, such as an x-ray or sputum sample, are needed to see if you have TB disease.



What if I had the BCG vaccine?

BCG is a vaccine for TB. This vaccine is not widely used in the United States, but it is often given to infants and small children in other countries where TB is common. The BCG vaccine does not usually protect adults against TB. You may still get TB infection or TB disease. Even if you have had the BCG vaccine, you will need a TB skin test or QFT to see if you may have TB infection or TB disease.

What should I do if I have TB infection or TB disease?

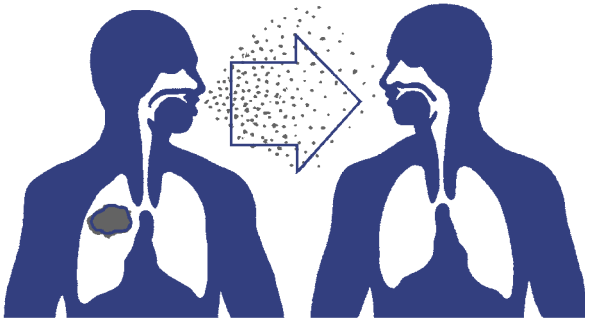
Get the required follow-up tests. Follow your doctor's advice and take the medicine as prescribed. Today, both TB infection and TB disease can be treated and cured with medication.

For more information on TB or to get a TB skin test, call your doctor or local health department.

For further information on TB visit:

CDC Division of Tuberculosis Elimination
Website at
www.cdc.gov/tb

Tuberculosis



Get the Facts

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control
and Prevention

CDC
SAFER·HEALTHIER·PEOPLE

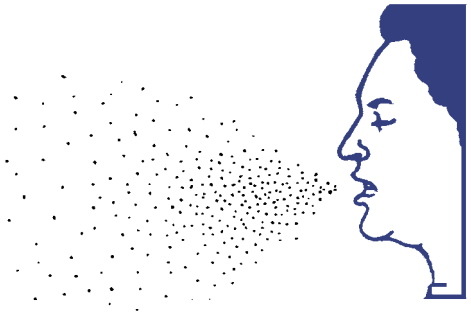
Tuberculosis: Get the Facts!

What is tuberculosis?

Tuberculosis (TB) is a disease that usually affects the lungs. TB sometimes affects other parts of the body, such as the brain, the kidneys, or the spine. TB disease can cause death if untreated.

How is TB spread?

TB germs are spread from person to person through the air. TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, laughs, or sings. TB is NOT spread by sharing silverware or cups, or sharing saliva when kissing someone.



What are the symptoms of TB?

People with TB disease often feel weak or sick, lose weight, have fever, and have night sweats. If their TB disease is in the lungs, they may also cough and have chest pain, and they might cough up blood. Other symptoms depend on what part of the body is affected.

What is the difference between TB disease and TB infection?

People with TB disease are **sick** from the large number of TB germs that are active in their body. They usually have one or more of the symptoms of TB disease. These people may pass the TB germs to others. TB disease can cause permanent body damage and death. Medicines which can cure TB disease are given to these people.

People with TB infection also have the germs that cause TB in their body. But they are **not sick** because there are not as many of the germs, and the germs lie dormant (sleeping) in their body. They cannot spread the germs to others. However, these people could develop TB disease in the future, especially if they are in one of the high-risk groups listed under "Who gets TB disease?" People with TB infection can take medicine to prevent them from developing TB disease.

Who gets TB disease?

Once a person has TB infection, he or she has a higher chance of getting TB disease if the person

- Has HIV infection
- Has been recently infected with TB germs (in the last 2 years)
- Has other health problems, like diabetes, that make it hard for the body to fight germs
- Uses alcohol or injects illegal drugs
- Was not treated correctly for TB infection in the past

How can I tell if I have TB?

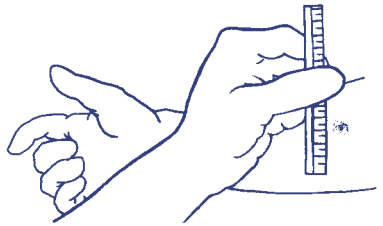
Get a TB skin test or the QuantiFERON®-TB Gold (QFT) blood test. If you have a positive reaction to either of the tests, you will probably be given other tests to see if you have TB infection or TB disease.

Where can I get a TB skin test or QFT?

You can get a TB skin test from your doctor or local health department. You may be able to get the QFT at your local health department.

How are the TB tests given?

For a TB skin test, a health care worker uses a small needle to put some testing material, called tuberculin, just under your skin. This is usually done on the lower inside part of your arm. After you get the test, you must return in 2 to 3 days to see if there is a reaction to the test. If there is a reaction, the size of the reaction is measured.



If your health department does offer the QFT, some of your blood is taken for the test. You will be instructed on how to get the results of your test.

What if the test is negative?

A negative skin test usually means you are not infected. However, the test may be falsely negative if you were infected recently. It usually takes 2 to 10 weeks after exposure to a person with TB disease for your skin