Mental Health – Adult Intake Checklist:

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

☐ Request for Service
☐ Demographic Entry I
☐ GAINS Form
☐ Notice of Rights - Medicaid
☐ Notice of Rights - Non-Medicaid
☐ SCL – 90
☐ ACE Survey
☐ Application for Services/ Consent to Services/ Advocacy etc.
☐ Fee Policy and Fee Agreement

Additional Reading Material
Advance Directives Advocacy Groups
HIPPA Letter
Notice of Privacy Practices

Palouse River Counseling

Telephone Request for Mental Health Services -- **Within 14 days!**

Name of Person making the request and relationship to client**:** _____

Are you the legal guardian (if client is under 13 years of age): ❑ Yes ❑ No

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____ Age: _____

City, State, Zip: _____

Telephone: _____ Message Number: _____ Work Number: _____
OK to ID: ❑ Yes ❑ No OK to ID: ❑ Yes ❑ No OK to ID: ❑ Yes ❑ No

Client Gender Identification: ❑ Male ❑ Female Client's Marital Status: _____ WSU Student? ❑ Yes ❑ No

GENERAL Reason for Seeking Counseling: _____

_____

Prior client? ❑ Yes ❑ No Currently an open chemical dependency client? ❑ Yes ❑ No Have you ever had a different last name: ❑ Yes ❑ No

If yes, previous last name: _____

_____ Are you currently supervised by the Department of Corrections?
_____ Are you currently under court supervision/probation? _____ (probation officer)

Referred to PRC by: ❑ Self ❑ Other (*If other, provide information below*) ❑ Special Accommodation needed? _____

Name: _____ Telephone: _____

Is this service mandated by someone? ❑ Yes ❑ No (*If yes, provide information below*)

Name: _____ Telephone: _____

Primary Care Provider/Physician: _____ Telephone: _____

Medical Center/City, State: _____

Do you have insurance: ❑ Yes ❑ No Primary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship of Policy Holder to client: _____ Insurance ID #: _____

Insurance company phone number (back of insurance card): _____
** Remind the caller they are responsible for contacting their physician and/or their insurance company to get required pre-authorization **

Medicaid: ❑ Yes ❑ No Medicare: ❑ Yes ❑ No Private Pay: ❑ Yes ❑ No

STAFF MEMBER RECEIVING THIS REFERRAL: I have explained to the caller that he or she must bring to their intake appointment all information relevant to their particular financial circumstances as described above. I have also explained that if they arrive at the scheduled time without the required information they may choose to keep their appointment, but be billed for the full intake fee.

Staff member completing form: _____ Time of Day: Start: _____ Length of Time: _____

Date of first offered service: _____

Client assigned to: _____ Intake Date: _____ Time: _____

❑ Request for Service entered into computer by: _____

❑ Client is not longer seeking services. Reason for no longer seeking services _____

_____

Attempts to schedule an intake appointment (Please indicate No Answer, Left Message, Not At Home, etc.):

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

DATE: _____ TIME: _____

COMMENTS: _____

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:** _____

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

ACE Survey

This ACE Survey is a snapshot of exposure to adverse childhood experiences and protective factors. It covers nine common forms of adverse childhood experiences and typical supports during your childhood that will support effective assessment and help customize treatment and service interventions. This survey can be used as a tool to learn about how early childhood experiences impact an individual over a lifespan and explore how current symptoms/behavior may be linked to early childhood experiences. Completing the following survey is optional and you can be provided with an opportunity to take the survey at a later date. If you would like more information about the ACE survey, please ask your clinician or go to https://www.cdc.gov/violenceprevention/acestudy/about.html

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

Revised 1/2017

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each 0ther?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Please continue on reverse side of this page.

Protective Factors Questionnaire

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.
Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.
Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.
Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.
Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.
Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.
Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.
Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.
Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____
Of these circled, how many are still true for me? _____

Name_____ ID# _____Date _____

SCL-90

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, select one of the numbered descriptors that best describes HOW MUCH THAT PROBLEM HAS BOTHERED OR DISTRESSED YOU DURING THE PAST WEEK, INCLUDING TODAY. Circle the number in the space to the right of the problem and do not skip any items. Use the following key to guide how you respond:

Circle 0 if your answer is NOT AT ALL
Circle 1 if A LITTLE BIT
Circle 2 if MODERATELY
Circle 3 if QUITE A BIT
Circle 4 if EXTREMELY

Please read the following example before beginning:

Example: In the previous week, how much were you bothered by:

Backaches 0 (1) 2 3 4

In this case, the respondent experienced backaches a little bit (1).
Please proceed with the questionnaire.

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1.	Headaches	0	1	2	3	4
2.	Nervousness or shakiness inside	0	1	2	3	4
3.	Unwanted thoughts, words, or ideas that won't leave your mind	0	1	2	3	4
4.	Faintness or dizziness	0	1	2	3	4
5.	Loss of sexual interest or pleasure	0	1	2	3	4
6.	Feeling critical of others	0	1	2	3	4
7.	The idea that someone else can control your thoughts	0	1	2	3	4
8.	Feeling others are to blame for most of your troubles	0	1	2	3	4
9.	Trouble remembering things	0	1	2	3	4
10.	Worried about sloppiness or carelessness	0	1	2	3	4
11.	Feeling easily annoyed or irritated	0	1	2	3	4
12.	Pains in heart or chest	0	1	2	3	4
13.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
14.	Feeling low in energy or slowed down	0	1	2	3	4
15.	Thoughts of ending your life	0	1	2	3	4
16.	Hearing voices that other people do not hear	0	1	2	3	4
17.	Trembling	0	1	2	3	4
18.	Feeling that most people cannot be trusted	0	1	2	3	4
19.	Poor appetite	0	1	2	3	4

SCL-90 (*continued*)

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
20.	Crying easily	0	1	2	3	4
21.	Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	Feeling of being trapped or caught	0	1	2	3	4
23.	Suddenly scared for no reason	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling afraid to go out of your house alone	0	1	2	3	4
26.	Blaming yourself for things	0	1	2	3	4
27.	Pains in lower back	0	1	2	3	4
28.	Feeling blocked in getting things done	0	1	2	3	4
29.	Feeling lonely	0	1	2	3	4
30.	Feeling blue	0	1	2	3	4
31.	Worrying too much about things	0	1	2	3	4
32.	Feeling no interest in things	0	1	2	3	4
33.	Feeling fearful	0	1	2	3	4
34.	Your feelings being easily hurt	0	1	2	3	4
35.	Other people being aware of your private thoughts	0	1	2	3	4
36.	Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	Having to do things very slowly to insure correctness	0	1	2	3	4
39.	Heart pounding or racing	0	1	2	3	4
40.	Nausea or upset stomach	0	1	2	3	4
41.	Feeling inferior to others	0	1	2	3	4
42.	Soreness of your muscles	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	0	1	2	3	4
44.	Trouble falling asleep	0	1	2	3	4
45.	Having to check and double-check what you do	0	1	2	3	4
46.	Difficulty making decisions	0	1	2	3	4
47.	Feeling afraid to travel on buses, subways, trains	0	1	2	3	4
48.	Trouble getting your breath	0	1	2	3	4
49.	Hot or cold spells	0	1	2	3	4
50.	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51.	Your mind going blank	0	1	2	3	4
52.	Numbness or tingling in parts of your body	0	1	2	3	4
53.	A lump in your throat	0	1	2	3	4
54.	Feeling hopeless about the future	0	1	2	3	4
55.	Trouble concentrating	0	1	2	3	4

SCL-90 (*continued*)

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
56.	Feeling weak in parts of your body	0	1	2	3	4
57.	Feeling tense or keyed up	0	1	2	3	4
58.	Heavy feelings in your arms or legs	0	1	2	3	4
59.	Thoughts of death or dying	0	1	2	3	4
60.	Overeating	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62.	Having thoughts that are not your own	0	1	2	3	4
63.	Having urges to beat, injure, or harm someone	0	1	2	3	4
64.	Awakening in the early morning	0	1	2	3	4
65.	Having to repeat the same actions such as touching, counting, washing	0	1	2	3	4
66.	Sleep that is restless or disturbed	0	1	2	3	4
67.	Having urges to break or smash things	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	0	1	2	3	4
69.	Feeling very self-conscious with others	0	1	2	3	4
70.	Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71.	Feeling everything is an effort	0	1	2	3	4
72.	Spells of terror or panic	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74.	Getting into frequent arguments	0	1	2	3	4
75.	Feeling nervous when you are left alone	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	0	1	2	3	4
77.	Feeling lonely even when you are with people	0	1	2	3	4
78.	Feeling so restless you couldn't sit still	0	1	2	3	4
79.	Feelings of worthlessness	0	1	2	3	4
80.	Feeling that familiar things are strange or unreal	0	1	2	3	4
81.	Shouting or throwing things	0	1	2	3	4
82.	Feeling afraid you will faint in public	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	0	1	2	3	4
85.	The idea that you should be punished for your sins	0	1	2	3	4
86.	Feeling pushed to get things done	0	1	2	3	4
87.	The idea that something serious is wrong with your body	0	1	2	3	4
88.	Never feeling close to another person	0	1	2	3	4
89.	Feelings of guilt	0	1	2	3	4
90.	The idea that something is wrong with your mind	0	1	2	3	4

Reference: Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale—Preliminary Report. *Psychopharmacol. Bull. 9*, 13–28.

Palouse River Counseling
Mental Health 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
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

ADVANCE DIRECTIVES

Having Your Say

You have the right to participate in your mental health care.

How Do I Have My Say?

It is our policy to make information about advance directives known to both you and your family/significant other. We encourage open and thoughtful discussion about your directive, so treatment staff have the opportunity to discuss your desires and plan your treatment as you indicate. We invite all our service recipients to take direct responsibility, to ask questions, and to seek answers that will help them make the best decision about their mental health treatment.

The State of Washington recognizes your right to make decisions about your mental health care. An "advance directive" allows an adult with a mental illness to specify how treatment decisions should be made in the event that he/she becomes unable to make a well-reasoned choice.

This can be included as part of your treatment plan or be a separate document.

Do I Really Need An Advance Directive?

The decision to have an advance directive is a personal one. You are not required by law to have an advance directive. You may want to talk to your family and/or the mental health professional who is providing your treatment services about an advance directive.

Advance directives offer enormous benefits to service recipients, family members and providers alike. As a recipient of mental health services, having an advance directive also offers the potential to minimize conflict and to foster a collaborative, therapeutic relationship with treatment staff.

Advance directives have some limits. They will not prevent involuntary treatment, if needed, and may not be useful in situations which are not anticipated.

When Can I Create My Advance Directive?

You can create an Instructional Directive or Durable Power of Attorney for Health Care at any time. Forms can be provided upon request, by calling the numbers on the back of this page.

There Are Two Types Of Advanced Directive:

1. Durable Power of Attorney for Health Care

This allows the person to give someone else legal authority to make health care decisions for them if they are unable to do so themselves.

2. Instructional Directive

This is a document that provides specific instruction about the treatment a person wishes to receive in the event that a well-reasoned choice is not possible due to a mental illness. You will want to understand what the limits to Advance Directives are as you decide how they fit your needs.

If I Have An Advance Directive May I Change It?

Yes, you may change or cancel an instructional directive or durable Power of Attorney for Health Care at any time. You may do this by destroying the document, putting your change in writing, or telling your family or the mental health professional who is treating you about the change.

Where Do I Get More Information on Advance Directives?

Washington Protection & Advocacy Systems
1-800-562-2702

State of Washington
Division of Mental Health
Office of Consumer Affairs
1-800-446-0259

If you have a complaint regarding noncompliance with Advance Directive policies please contact:

Washington State Department of Health
(800) 525-0127
TTY users dial 711
www.doh.wa.gov

Quality Improvement and Assurance
Mental Health Division
1-888-713-6010

Palouse River Counseling

ADVOCACY GROUPS

Listed below are the phone numbers of three mental health advocacy groups, and the GCRSN OMBUDS Service.

PAMI

Palouse Alliance for the Mentally Ill
Zoe Cooley
(208) 835-3071

Anne Demikis
(509) 332-6947

SAMI

Spokane Alliance for the Mentally Ill
(509) 838-5515

OMBUDS SERVICES OF THE GREATER COLUMBIA REGIONAL SUPPORT NETWORK (GCRSN)

Voice/TDD (509) 783-7333
Toll Free 1-(800) 257-0660
More information about the Ombuds Services is available at the reception desk

Palouse River Counseling

340 N.E. Maple St., Pullman, WA 99163 Voice (509) 334-1133 TDD 1-800-833-6388 FAX (509) 332-1608
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

NOTICE OF PRIVACY PRACTICES

Palouse River Counseling * NE 340 Maple * Pullman, WA 99163

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.

If you have any questions about this Privacy Notice, please contact our Privacy officer at (509) 334-1133.

I. Introduction

This Notice of Privacy Practices describes how we may use and disclose your (or your child's/children's) protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you (or your child/children) and a brief description of how you may exercise these rights. This Notice states the obligations we have to protect your health (or your child's/children's) information. "Protected health information" means health information, including identifying information about you (or your child/children); we have received from you or from other health care providers, health plans, employers, Department of Social and Health Services, Department of Child and Family Services, or health care clearinghouses. It can include information about your (or your child's/children's) past, present, or future physical or mental health condition(s), the treatment plan for your (or your child's/children's) condition, and methods of payment for health care services. We are required by law to maintain the privacy of your (or your child's/children's) health information and to provide you with this notice of our legal duty(ies) and privacy practices with respect to your (or your child's/children's) health information. We are also required to comply with the terms of our current Notice of Privacy Practices.

II. Use and Disclosure of Health Information

We will use and disclose your (or your child's/children's) health information as described in each category listed below. Each category will explain what is meant in general, but not describe all specific uses or disclosures of health information. You as the patient have the right to request that Palouse River Counseling restrict the release of your (or your child/children's) personal healthcare information for the use of treatment, payment, or health care operations. However, Palouse River Counseling is not required to agree to a request for the restriction, PRC has a policy by which they will accept or deny such request(s).

A. Uses and Disclosures that may be made with your written consent

1. For Treatment. Once you have signed our Consent to Use and Disclose Health Information, we will use and disclose your (or your child's/children's) health information to provide health care and any related services. We will also use and disclose health information to coordinate and manage you health care and related services. For example, we may need to disclose information to a case manager who is responsible for coordinating care outside of this agency. We may also disclose your health information among our clinicians and other staff. This may include clinicians, Medical Doctor, Nurse Practitioner, other than your (or your child's/children's) principal clinician, who work at Palouse River Counseling.

2. For Payment. Once you have signed the Consent to Use and Disclose Health Information, we may use or disclose your (or your child's/children's) health information so that the treatment and services received are billed to, and payment is collected from, a health plan or other third party payer. For example, we may disclose your (or your child's/children's) health information to permit your health plan to take certain actions before your health plan approves or pays for your services. These actions may include:

- Making determination of eligibility or coverage for health insurance;
- Reviewing your services to determine if they were medically necessary;

- Reviewing your services to determine if they were appropriately authorized or certified in advance of your care; or
- Reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges of your care.

Additionally, your health plan may ask us to share your (or your child's/children's) health information in order to determine if the plan will approve additional visits to your therapist. However, if you choose not to use your insurance for your (or child/children's) services, we will not send information to your insurance company.

3. For Health Care Operations. Once you have signed our Consent to Use and Disclose Health Information, we may use and disclose health information about you (or your child/children) for our operations. These uses and disclosures are necessary to run our organization and make sure that our clients receive quality care. These activities may include, for example, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, licensing, accreditation, business planning and development, and general administrative activities.

Palouse River Counseling may combine the health information of several of our clients to decide what additional services we should offer, what services are no longer being used, and whether certain new treatments are effective. We may also combine health care information with information received from other providers to compare how we are doing and see where we can make improvements in our services. When we combine our health information with the information from other providers, we will remove any identifying information so others may use it to study health care or health care delivery without identifying specific clients.

We may also use and disclose your (or your child's/children's) health information to contact you to remind you of your appointment.

Finally, we may use and disclose your (or your child's/children's) health information to inform you about possible treatment options and alternatives that may be of interest to you.

B. Uses and Disclosures that may be made without Your Consent or Authorization, but for which you will have an opportunity to object.

1. Person(s) Involved in your care. We may provide health information about you (or your child/children) to someone who helps pay for your care. We may use or disclose your (or your child's/children's) health information to notify or assist in notifying family members, personal representatives, or any other person(s) that is (are) responsible for your (or your child's/children's) care of your (or your child's/children's) location, general condition, or death. Palouse River Counseling may also use or disclose your (or your child's/children's) health information to any agency assisting in disaster relief efforts or to coordinate uses and disclosures for this purpose to family or other individuals involved in your (or your child's/children's) health care.

In certain circumstances, we may disclose health information about you (or your child/children) to a friend or family member who is directly involved in your (or your child's/children's) care. If you're physically present and have the capacity to make health care decisions, your (or your child's/children's) health information may only be disclosed with your agreement to the person(s) you designate to be involved in your (or your child's/children's) care.

However, if you (or your child/children) are involved in an emergency situation, Palouse River Counseling may disclose your (or your child's/children's) health information to a spouse, parent (including a non-custodial parent), or a friend so that such person may assist in your care. In each individual case we will determine whether the disclosure is in your (or your child's/children's) best interest and, if so, we will only disclose information that is directly relevant to participation in your (or your child's/children's) care. And, if you are not in an emergency situation, but are unable to make health care decisions, we will disclose your health information to:

- A person(s) designated to participate in your care in accordance with an advance directive validly executed under state law.

- Your (or your child's/children's) guardian or other fiduciary if one has been appointed by a court, or
- Where applicable, the state agency responsible for consenting to your care.

Palouse River Counseling (PRC) is permitted to release patient information if PRC has a good faith belief that the disclosure is necessary to prevent or lessen a serious and/or imminent threat to the health and/or safety of the patient or others within the community. Such a release can be made to a person(s) who is reasonably able to lessen and/or prevent this threat. This may include, depending on the circumstances of the threat, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good faith belief can assist in lessening and/or preventing the threat. In the case of a minor, Palouse River Counseling can disclose protected health information to the child's parent (including a non-custodial parent) or guardian as the child's personal representative. In the case of a minor who has reached the age of 13 and can enter into or leave treatment without parental consent, the parents are not treated as the minor's personal representative. However, if PRC believes in good faith that the teen presents a danger to themselves and/or others, than PRC can release information to the parent (including a non-custodial parent) or guardian or to other person(s) who can assist in lessening and/or preventing the threat.

III. Uses and Disclosure of Your Health Information with your Permission.

Uses and disclosures not described in Section II of this Notice of Privacy will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization at any time. If you revoke an authorization we will not make any further uses or disclosures of your (or your child's/children's) health information under that authorization, unless we have already taken action relying upon the uses or disclosures you have previously authorize.

If an individual has been given a health care power of attorney they have the right to access your (or your child's/children's) medical records. However, if Palouse River Counseling reasonably believes that you (or your child/children) has been or may be a victim of domestic violence, abuse, or neglect by the client's personal representative, or that treating a person as a client's personal representative could endanger you (or your child/children), than PRC can choose not to treat that person as your (or your child/children's) personal representative.

If an individual is the personal representative of an adult or an emancipated minor, the individual has access to the client's protected health information. However, the scope of the access is dependent on the authority granted to the personal representative. If the personal representative is authorized the make health care decisions, then he or she may have access to yours (or your child/children's) protected health information regarding general health care. However, if the authority is limited, than the personal representative can only have access to the personal health information that is relevant to their decision making within his/her authority.

IV. Your Rights Regarding Your (or your child's/children's) Health Information

A. Right to Inspect and Copy

You have the right to request an opportunity to inspect, with your (or your child's/children's) counselor present, or copy health information used to make decisions about your (or your child's/children's) care – whether they are decisions about treatment or payment. You must submit your request in writing to Palouse River Counseling's Privacy Officer at NE 340 Maple, Pullman, WA 99163. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, and supplies associated with your request. Palouse River Counseling has 14-days in which to respond to any such requests. We may deny your request to inspect or copy your (or your child's/children's) health information in certain limited circumstances, for example, if you wish to see information generated by other agencies or if the request is not made in writing. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request has been reviewed and a decision made. Once the review is completed, we will honor the decision made by the reviewer.

You have the right to request any of your confidential patient information in electronic form. You can also designate a third party to be the recipient of the your confidential patient health information.

Under the HIPAA privacy rule, Palouse River Counseling is not required to provide you access to any oral information regarding you (your child/children). You can only request information that is contained in your (your child/children's) designated record set, which does not include oral information. Palouse River Counseling is not required under the HIPAA privacy rule to tape or digitally record oral communication, nor is PRC required to retain taped or digitally recorded information after it has been transcribed.

B. Right to Amend.
For as long as Palouse River Counseling retains your (or your child's/children's) records, you have the right to request us to amend any health information used to make decisions your (or your child's/children's) care – whether these decision relate to treatment or payment. To request an amendment, you must submit a written request to Palouse River Counseling's Privacy Officer at NE 340 Maple, Pullman, WA 99163, and tell us why you believe the information is incorrect or inaccurate. Again, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend health information that includes:

- Documentation not created directly by our agency, unless the person(s) or entity(ies) that created the health information is no longer available to make the amendment;
- Documentation that is not part of the health information we maintain to make decisions about your care;
- Documentation is not part of the health information that you would be permitted to inspect or copy; or
- Documentation is accurate and complete.

If we deny your request to amend, you will be sent a written notification of the denial that will state the basis for the denial and offer you the opportunity to provide a written statement disagreeing with our decision. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request. If you choose to submit a written statement of disagreement, Palouse River Counseling has the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal, along with the original request and denial, to all future disclosures of the health information that is the subject of your request.

C. Right to an Accounting of Disclosures.
You have the right to request that Palouse River Counseling provide you with an accounting of all disclosures we have made of your health information. This list will not include certain disclosures of your health information, for example, those we have made for the purposes of treatment, payment, and health care operations. To request an accounting of disclosures, you must submit your request in writing to the Palouse River Counseling's Privacy Officer at NE 340 Maple, Pullman, WA 99163. For your convenience, you may submit your request on a form called a "Request For Accounting", which can be obtained from our Privacy Officer. The request should include the time period for which you wish to receive an accounting. **This time period may not exceed more than six years and not include dates prior to April 14, 2003**. The first accounting your request within a twelve month period will be free. For additional requests during the same 12 month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request before we incur any costs.

D. Right to Request Restrictions.
You have the right to request a restriction on the health information we use or disclose about you (or your child/children) for treatment, payment or health care operations. You may also ask that any part (or all) of your (or your child's/children's) health information not to be disclosed to family members, non-custodial parents, or friends who may be involved in your (or your child's/children's) care or for notification purposes as described in Section II (B)(2) of this Privacy Notice. To request a restriction, you must either include it (with the approval of Palouse River Counseling) in the Consent for Use or Disclosure Form or request the restriction in writing addressed to Palouse River Counseling's Privacy Officer at NE 340 Maple, Pullman, WA 99163. The Privacy Officer will ask you to sign a new consent form which will include the restrictions. Palouse River Counseling is not required to agree to the restriction(s) that you may request. If

we do agree, we will honor your request unless the restricted health information is needed to provide you (or your child/children) with emergency treatment.

E. Right to Request Confidential Communications.
You have the right to request that Palouse River Counseling communicate with you about your (or your child's/children's) health care only in a certain location or through certain methods, for example we can only contact you at work or by email. To request such confidential communication, you must make your request in writing to Palouse River Counseling's Privacy Officer at NE 340 Maple, Pullman, WA 99163. We will accommodate all reasonable requests. You do not need to give a reason for the request, but your request must specify how or where you wish to be contacted.

F. Right to a Paper Copy of this Notice.
You have the right to obtain a paper copy of this Privacy Notice at any time. To obtain a paper copy, contact Palouse River Counseling's Privacy Officer at NE 340 Maple Drive, Pullman, WA 99163.

V. Confidentiality of Substance Abuse Records

For individuals who have received treatment, diagnosis or referral for treatment from our drug or alcohol abuse programs, the confidentiality of drug or alcohol abuse records is protected by additional federal law and regulations. As a general rule, Palouse River Counseling may not tell a person outside the program that you attend (or attended) any of these programs or disclose any information identifying you as an alcohol or drug abuser, unless:

- You authorize the disclosure in writing; or
- The disclosure is permitted by a court order; or
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation purposes; or
- You threaten to commit a crime directed at the drug abuse or alcohol program or against any person who works for Palouse River Counseling drug abuse or alcohol programs.

A violation by us of the federal law and regulations governing drug or alcohol abuse is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to the appropriate authorities.

VI. Complaints/Breaches of Confidential Information

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. In the event that there is a breach of confidential patient health information, you will be notified by the Privacy Officer at Palouse River Counseling. If you feel that there has been a breach of your (or child/children's) confidential patient health information that PRC is not aware of, please contact our office at 509-334-1133. To file a complaint with us, contact our office at 509-334-1133. All complaints must be submitted in writing. Our Privacy Officer, who can be contacted at NE 340 Maple, Pullman, WA 99163, will assist you with writing your complaint, if you request such assistance. Palouse River Counseling will not retaliate against you for filing a complaint.

VII. Changes of this Notice

Palouse River Counseling reserves the right to change the terms of our Privacy Notice. We also reserve the right to make the revised or changed Privacy Notice effective for all health information we already have about as well as any health information we receive in the future. We will post a copy of the current Privacy Notice at our main office. You may also obtain a copy by calling us at 509-334-1133 and requesting that a copy be sent to you in the mail or by asking for one any time you are at our office.

VIII. Who will follow this Notice

This Notice of Privacy will be followed by all employees of Palouse River Counseling.