MR#: | | | | | | | Date: | | | – | | | – | | | | |
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AltaPointe Health
Alabama Department of Mental Health
of Mental Health And
Substance Abuse Division
UNCOPE SCREENING
(Age 18 and Above)

Submitting Worker: _____
Date of Screening: ____/____/_____
Date of Entry: _____/_____/_____

ASAIS ID: _____ MR#: _____ Program #: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Sex ___ Male ____ Female SS#: _____ Medicaid #: _____

Address: _____ City:_____State: _____ Zip Code: _____

County of Residence:_____ Home Phone: _____ Work Phone: _____

Marital Status: ___ Married ___ Separated ____ Common Law ____ Widowed ____ Divorced ____ Never Married

Head of Household ___ Yes ___ No Education: (years completed) _____

Race (check one blank): ___ Alaska Native (Aleut, Eskimo, Indian) ___ American Indian (other than Alaska Native) ___ Asian
___ Native Hawaiian or Other Pacific Islander ___ Black or African American ___ White ___ Other Single Race __ Two or More Races
___ Unknown

Ethnicity: (check one blank): ___ Not of Hispanic Origin ___ Puerto Rican ___ Mexican ___ Cuban ___ Other Specific Hispanic
___ Hispanic – Specific Origin not Specified ___ Unknown

UNCOPE - AGE 18 and ABOVE

In the past year, have you ever drank or used drugs more than you meant to? (1,2):
___ Yes ___ No

Have you every neglected some of your usual responsibilities because of alcohol or drugs? (2) :
___ Yes ___ No

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? (1,2):
___ Yes ___ No

Has anyone objected to your drinking or drug use? (3.1) OR has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use? (2):
___ Yes ___ No

Have you ever found yourself preoccupied with wanting to use alcohol or drugs? (2) OR Have you found yourself thinking a lot about drinking or using?:
___ Yes ___ No

Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom? (2,1):
___ Yes ___ No

Number of Positive Responses _____ (Two or more positive responses indicate possible abuse or dependence. Four or more positive responses strongly indicate dependence).

1. Brown, R.L. Leonard, T., Saunders, L.A. & Papasouliotis, O. (1997). A two-item screening test for alcohol and other drug problems, Journal of Family practice, 44, (2), 151-160.
2. Hoffman, N.G. & Harrison, P.A., (1995) SUDDS – IV Substance Use Disorders Diagnostic Schedule. Smithfield, RI: Evince Clinical Assessments.
3. Hoffman, N.G. (1995) TAAD: Triage Assessment for Addictive Disorders, Smithfield, RI: Evince Clinical Assessments.

PRE-INTAKE

DATE_____

FULL LEGAL NAME_____

DATE OF BIRTH ____/____/_____

SOCIAL SECURITY #_____-_____-_____

ADDRESS_____

CITY_____**STATE**____**COUNTY**_____**ZIP**_____

1st, 2nd and 3rd PREFERRED COMMUNICATION:

___Home Phone_____ ___Work Phone_____

___Cell Phone_____ ___Text_____

___Do Not Contact ___Regular Mail_____

___E-MAIL_____

MARITAL STATUS (MAIDEN NAME:_____**)**

____Legally Married ___Divorced ___ Never Married ___Separated
____Widowed ___Common Law/Cohabitating

Primary Language	**Race**	**Ethnic Origin**
___English	___Alaskan Native	__Cuban
___French	___American Indian	__Mexican
___German	___Asian/Pacific Islander	__Not Hispanic
___Russian	___Black/African American	__Hispanic
___Spanish	___White/Caucasian	__Puerto Rican
___Other	___Other	

Do you need an interpreter? ____Yes ____No

Place of Birth (City, State and County)_____

Highest grade completed?_____

Employment Status	**Referral Source**
_____Full Time	_____ Self
_____Part time	_____ DHR
_____Disabled	_____ Federal
_____Unemployed	_____ State/Alabama
_____Not looking for work	_____ Out of State
_____Student	_____ Baldwin County
_____Retired	_____ Probation/Parole
_____Homemaker	_____ Other_____

Veteran___Yes___No

If yes, what branch?

_____Army

_____Airforce

_____Navy

_____Marines

Veteran:

_____Currently on Active Duty

_____Previously on Active Duty

_____Military Dependent

Do you have any insurance?____Yes____No

INDIVIDUAL INCOME $_____

TOTAL HOUSEHOLD INCOME $_____

Expected Payment Source

___Self

___Worker's Compensation

___Commercial Insurance (BCBS, UHC)

___Medicare

___Medicaid

___Medicare/Medicaid

___Other_____

Primary Source of Income

___Wages/Salary

___Public Assist. ie (Food Stamps,TANF)

___Retirement/Pension

___Disability (SSI, SSDI)

___None

___Other

Are you pregnant? ___Yes ___No

Hearing Status ___Good Hearing ____Hard of Hearing ____Deaf

ARE YOU IN DRUG COURT? ___*Yes* ___*No*

RESIDENTIAL CODE

_____Independent Living

_____Inpatient Psychiatric Hospital

_____Jail/Correctional Facility

_____Nursing Home

_____Other Institutional Setting

_____(Children Only) Private Residence

_____State Psychiatric Hospital

NUMBER LIVING IN HOUSEHOLD _____

RESIDENTIAL ARRANGEMENT

_____Alone

_____Lives With Guardian

_____Lives With Paid Careprovider

_____Unknown

_____With Children

_____With Non-Relatives

_____With Other Relatives

_____With Spouse

Next of Kin

Name_____Relationship_____

Phone Number_____ Reside Together: YES NO

Emergency Contact

Name_____Relationship_____

Phone Number_____ Reside Together: YES NO

MR#: ☐☐☐☐☐☐ EP: ☐☐ Date: ☐☐ – ☐☐ – ☐☐☐☐
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ALTAPOINTE HEALTH
STATEMENT OF UNDERSTANDING AND CONSENTS

CONSUMER NAME: _____

Review and initial each applicable area:

All Programs

_____ **Treatment/ Psychiatric Care**: I hereby authorize AltaPointe to provide me with treatment services, and if it is my child or ward, I hereby give consent for treatment:
Services may include the prescription of psychoactive medications and the administration of those medications by approved program staff. Emergency medications may be given to the consumer (by mouth or injection) to prevent harm to themselves or others.
Children and adolescent inpatient consumers will receive educational services on site as appropriate. Classrooms may consist of students receiving special and/or regular educational services. Due to our emphasis on treatment of emotional and behavioral difficulties consumers will not be eligible to receive the same number of credits as they would on a public school campus.

_____ **Consent for Follow-up contact:** I consent to AltaPointe staff members contacting **__myself ___other contact** by letter, questionnaire or telephone for establishing my current condition. I understand this information will be held in confidence and will not be disclosed without my written consent. I further understand this consent for follow-up will remain valid for a period of **ONE** year following my discharge from the program. I understand that I may revoke this consent at any time in writing. □ **I do not want to be contacted**.
Name: _____Address: _____ Phone#: _____

_____ **Health Information Exchange (HIE):** AltaPointe participates in a HIE called Care Quality. I understand that any physician or hospital that participates in the Care Quality HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You many chose to Opt-Out of allowing your health information to be shared through the Care Quality HIE by requesting an Opt-out form.
All other releases will follow the practices explained in Your Notice of Privacy Practices.

_____ **Payment Agreement:** For and in consideration of services rendered by AltaPointe, consumer (responsible person) herby agrees to and guarantees payment of all AltaPointe charges incurred for the account of the consumer from the date of admission until discharge. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive at AltaPointe. If the Probate Court placed me at AltaPointe, I understand that my insurance along with contract fees will be used to pay for services rendered while I am receiving services at AltaPointe.

I also understand that that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand I should contact AltaPointe if there are any changes to my insurance. A no-show fee may be charged if applicable.

Methods of Payment – Our office accepts the following payment methods: Cash, Personal Check, Credit Cards and Money Orders.
There will be a $25.00 NSF charge for all returned checks.

_____ **Fee Schedule:** I understand that I am responsible for payment for services rendered by AltaPointe Health, Inc. at its standard rates provided to me on the fee schedule.

_____ **Self-Pay –** I agree to pay AltaPointe in full for services rendered.

_____ **Medicaid:** Consumer certified that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Consumer authorizes any holder of medical or other information about Consumer to release to the respective State Medicaid Agency or its intermediaries or carries any information needed for this or a related Medical claim. Consumer requests that payment of authorized benefits be made on his/her behalf.

_____ **Medicare:** Consumer certified that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Consumer authorizes any holder of medical or other information about Consumer to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medical claim. Consumer requests that payment of authorized benefits be made on his/her behalf.

_____ **Assignment of Insurance Benefits and Agreement to Pay Any Balance**: Consumer (responsible party) irrevocably assigns and transfers to AltaPointe all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering consumer, for the payment of treatment and medical care being provided. Consumer (responsible party) authorizes payment directly to AltaPointe Health of said medical reimbursement benefits. Consumer (responsible party) is responsible for and co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the AltaPointe charge in full, consumer (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that AltaPointe does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.


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MR#: | | | | | | | EP: | | | Date: | | | – | | | – | | | | |
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AltaPointe Health Statement of Understanding and Consents pg. 2

_____ **Integrated Healthcare Pharmacy Services**: As a consumer at AltaPointe Health my prescriptions may, but are not required, to be filled at the Integrated Healthcare Pharmacy located at Gordon Smith Drive. AltaPointe Health has an ownership interest in Integrated Healthcare Pharmacy and offers the on-site pharmacy services for the convenience of the consumer. It is the consumer's decision as to where he/she chooses to fill their prescription.

_____ **Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment**: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

_____ **Family Involvement**: Family involvement is an integral part of treatment especially when treating children and adolescents. I agree to make every reasonable effort to assist my or my child's therapist in scheduling a convenient time for this family therapy session. I do understand that failure to meet this requirement can result in denials of insurance payment related to non-compliance with treatment.

_____ **Responsibility for Destruction of Property**: The undersigned understands that consumers are responsible for any damage to or destruction of AltaPointe property, or property belonging to others which may be located at AltaPointe. The undersigned and/or legal guardian agree to accept liability of, and reimburse AltaPointe or other owners of property which the consumer may damage or destroy.

_____ **Confidentiality of Information and Group Participation**: I understand that any information which is disclosed to me while I am a consumer at this facility is confidential and that this information is protected by Federal law. I understand that this means that I will respect the rights of other participants by not talking with others outside the facility about what is said in treatment groups.

_____ **Consumer Rights Statement**: I understand that AltaPointe subscribes to a Consumer Rights Statement, which has been made available to me. I have had the opportunity to have the Consumer Rights Statement explained to me.

_____ **Grievance Process**: I have been furnished with a copy of the Grievance process and had it explained to me.

_____ **Procedure to Review Records**: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

_____ **Notice of Privacy Practices**: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of _____ will be held in confidence by the AltaPointe staff unless I give specific written consent for the release of information. In case of emergency AltaPointe is authorized to request or release that information which is essential to handle the emergency.

Also, AltaPointe staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage or sabotage.

The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a consumer's commission of a crime against AltaPointe property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).

_____ **Special Equipment**: I understand that special equipment, in the form of cameras, may be utilized at the facility for the safety of the consumers.

_____ **Rehabilitation Act:** It is the policy of AltaPointe, in compliance with Section 504 of the Rehabilitation Act of l973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a compliant with the Consumer Needs Specialist, AltaPointe Health, 5750-A Southland Drive., Mobile, Al. 36693.

_____ **Consent to Photographs**: I consent to have my photograph taken by the staff at AltaPointe as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of consumer identification, and will be used for identification purposes only when necessary during the course of my treatment.

_____ **Consent to Search**: I do hereby give my willing and informed consent to AltaPointe to search my personal belongings in my presence. **This consent is given to ensure that neither I nor anyone else in this facility has any prohibited items (dangerous objects, medications, contraband, or any other prohibited items)**. I do understand that this search would also be performed in the event of my leaving the facility by the appropriate clinical staff member as AltaPointe deems necessary. I do also understand that this search is to include socks and underwear.

_____ **Responsibility for Personal Articles**: Consumer (responsible person) acknowledges and agrees that AltaPointe does not assume responsibility for any personal possessions. Consumer and/or legal guardian acknowledges and agrees to accept responsibility for any personal possessions. Consumer acknowledges and agrees to accept responsibility for clothing and/or personal effects including dentures, eye glasses, hearing devices, etc.

_____ **Psychiatric Advance Directives:** ***(All Adult Programs)*** ___ I have a psychiatric advance directive and have provided a copy to AltaPointe. ___ I do not have a psychiatric advance directive, and have been provided information by AltaPointe

MR#: ☐☐☐☐☐☐ EP: ☐☐ Date: ☐☐ – ☐☐ – ☐☐☐☐
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AltaPointe Health Statement of Understanding and Consents pg. 3

Children's Outpatient Programs

_____ **Children's Outpatient Program Admission Agreement**: I have been furnished with a copy of the admission agreement and it has been explained to me.

Residential / Hospital Program

_____ **Seclusion & Restraint: The Last Resort**: I understand that AltaPointe's policy is to use Seclusion and Restraint only as a last resort. I have been given a copy of their policy and had the opportunity to ask questions. Physical restraint and/or seclusion may be used only in an emergency to protect the consumer or others from imminent risk of harming self or others. This procedure has been explained to me. I understand that this is not used as punishment, but only as an emergency procedure. I understand that an attempt will be made to contact:
Name _____ Relationship: _____
Phone Number: _____.

_____ **Consent for Participating in and Transport to Off-Ground Activities and therapies**: I give permission for me or my child to participate in off-ground activities such as movie, skating, museums, bowling, plays, etc., as approved by the attending physician. I understand that AltaPointe will provide reasonable supervision and will take reasonable precautions to provide for the safety and well-being of me and/or my child.

_____ **Adult Residential Services and Transitional Age Residential Financial/Medical/Dental Responsibility Agreement:** As a resident of a residential care home, I understand that (1) I am charged up to 75% of my monthly income or up to $750 for room and board. (2) My room, board charges may be changed if my income changes. I am responsible for up to 75% of all my income for room and board for those months for which I am eligible. (3) I will reimburse the program for all personal expenses incurred while a resident at AltaPointe Health to include, but is not limited to, any property damage personally created. (4) I understand that AltaPointe provides no routine medical and dental care. The provision of payment for routine and major medical costs must be made prior to admission through consumer resources, acceptable third party, or warranty by the sponsoring agent. I understand that I will be responsible for all my medical and dental care. If my relative/guardian/sponsor accepts responsibility for my medical and dental care, the signature is affixed below.

_____ **Child/Adolescent 24 Hour Care Program Elopement Report Permission**: I hereby give my permission as parent/legal guardian for the staff at AltaPointe to notify local law enforcement (police and/or sheriff's departments) of my child's full identity in the event of his/her unauthorized elopement from AltaPointe and/or the grounds. Identifying information may include name, birth-date, name(s) of parent(s), home address, and any other identifying information deemed potentially helpful in such a report.

_____ **Emergency Medical/Surgical Services**: I authorize and give my consent to AltaPointe staff to seek and obtain emergency medical/surgical treatment or dental treatment services as needed.

_____ **Medical Advance Directives:** ___I have a medical advance directive and have provided a copy to AltaPointe. ___ I do not have a medical advanced directive, and have been provided information by AltaPointe.

_____ **Consent for Sex education**: State and National Guidelines for child/adolescent treatment facilities require that the consumers be offered the chance to participate in sex education classes. AltaPointe will offer these classes on an informational level to those consumers who are of age to make their own informed decision or whose parents/guardians wish to have them enrolled. I give consent for my child to participate in informational sex education classes.

_____ **Consent to Attend Church-Related Activities**: I agree or give permission for my child to attend church-related activities while a consumer at AltaPointe. **(24 hour care programs)**

_____
Print Consumer's Name Consumer's Signature Date

_____ _____
Parent/Legal Guardian Signature Date Witness Signature/Credentials Date

_____
Witness Signature/Credentials **(required when signed with a mark)**

If consumer signature is not present mark reason:

_____ Consumer Unable to Sign

_____ Consumer refused to Sign (Show multiple attempts)
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____

Your rights as a Consumer in Substance Abuse Programs at AltaPointe Health

At AltaPointe Health, our goal is to make sure you get the quality mental health care you need. In order for you to get good care, there should be trust and respect between the consumer and those who give that care.

When you are a consumer at AltaPointe Health you have the right to:

- Be treated with respect, dignity and privacy.
- Be treated in a safe and humane place.
- Know the facts about your care, which has been designed just for you and is responsive to and respectful of your unique characteristics, needs and abilities.
- Be told where to get help if you have pain or other medical problems.
- Get help from others.
- To be informed of all program rules and client responsibilities prior to initiation of care, and the consequences of non-compliance.
- To provide input into the entity's service delivery processes through client satisfaction surveys and other avenues provided by the governing body.
- Receive services that are free of:
    - Physical Abuse
    - Sexual Abuse
    - Harassment
    - Physical Punishment
    - Psychological abuse, including humiliation
    - Threats
    - Exploitation
    - Coercion
    - Financial Abuse
- To report without fear of retribution, any instances of perceived abuse, neglect, or exploitation.
- To privacy, both inside and outside the program setting.
- To be informed of any potential restriction of rights that may be imposed.
- To be informed of the parameters of confidentiality.
- To be informed of client rights at the time of admission, both verbally and in writing.
- To be informed of the person who has primary responsibility for your care.

Before having services provided by AltaPointe Health:

- Give your written consent for treatment
- Withhold consent for treatment
- Be provided a copy of these consents

Facts about your care .... You have the right to:

- Be told what your illness is and what the doctor thinks is the best way to treat it,
- Be told how long your treatment will last,
- Be told the cost of your treatment and what part your insurance will pay, and if there are any limits on your treatment.
- To be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatments, services, and/or providers.

Facts about your medicine ... You have the right to:

- Take medicine only if ordered by a doctor.
- Be told about your medicine, including information about any side effects you may expect and how the medicine will help you.
- Be informed of any appropriate and available alternative treatments, services, and/or providers.
- Refuse to take any medicine, unless your care and treatment has been ordered by the court.

Making decisions about your care ... You have the right to:

- Have a treatment plan set up for your needs and to have it reviewed on a regular basis.
- Receive services based on your treatment plan and be provided with appropriate information to facilitate decision making regarding treatment.
- Help plan your treatment and have your family participate if you want.
- Express your preference of provider
- Refuse any treatment unless it has been ordered by a court.
- To the provision of care as according to accepted clinical practice standards within the least restrictive and most accommodating environment possible.

Getting help from others ... You have the right to:

- Get a second opinion, at your expense.
- Talk to an attorney.
- Have contact with the court system.
- Access protective services.
- Pray if you want to.
- Not be put into isolation or restrained or put on drugs unless as a part of your treatment.
- Refuse to do any work that would financially benefit AltaPointe Health.
- Formulate or have your Advanced Directive honored.
- To the availability of an adequate number of competent, qualified, and experienced professional clinical staff to ensure appropriate implementation of the client's service plan.

You have duties too. You should:

- Respect other people
- Talk to our staff
- Not touch other people in the wrong way
- Not destroy AltaPointe property
- Take your medicine
- Follow the rules
- Join in activities
- Not hurt other people or fight

If you feel that any of your rights have been violated or if you want further information, you may contact the following:

Alabama Department of Mental Health
1-800-367-0955

Department of Human Resources
(251) – 450-1800

Alabama Disabilities Advocacy Program
1-800-826-1675

AltaPointe Health Consumer Needs Department
(251) 450-4303

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe Health by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org

You may also call:

Elder Care at Public Health in Montgomery/Division of Health Care Facilities to report a complaint and/or ask questions about your Advance Directive at 1-800-356-9596, Monday – Friday 8 AM to 5 PM.

GRIEVANCE PROCESS

You may report any complaint/grievance to any employee of AltaPointe Health. All complaints received will be reported to the Consumer Needs Specialist.

- You will receive a response with possible solutions to you complaint within 10 working days from the Consumer Needs Specialist.
- If you are not satisfied with the solution, you may request that your complaint be reviewed by the Consumer Needs Committee.
- You will receive a response with a possible solution from the Consumer Needs Committee within 10 working days.
- If you are not satisfied with the solution offered by the Consumer Needs Committee, you may request that your complaint be reviewed by the Chief Executive Officer of AltaPointe Health.
- You will receive a response from the Chief Executive Officer within 30 days.

At any time, you may contact the following agencies regarding your complaint/grievance.

Department of Mental Health/Mental Retardation Office of Advocacy Services
(800) 367-0955

Department of Human Resources
(251) 450-1800

Alabama Disabilities Advocacy Program
(800) 826-1675

Consumer Needs Department
(251) 450-4303

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe Health by either calling (800) 994-6610 or emailing complaint@jointcommission.org

You may also call:

Elder Care at Public Health in Montgomery/Division of Health Care Facilities to report a complaint and/or ask questions about your Advance Directive.
(800) 356-9596
Monday-Friday 8am-5pm

AltaPointe Health

Procedure for Review of Records

Any consumer or legal representative of a consumer may request an opportunity to review his/her records to obtain information from his/her records at AltaPointe Health. Such a request must be submitted in writing on a facility provided *Release of Authorization to Disclose Protected Health Information* form.

Upon receipt of this request, the Health Information Department shall forward the consumer's request and medical record to the clinician for determination if release of information would be detrimental to the consumer.

If after review the clinician determines the information may be released, the requested information will be copied and released to the consumer.

The copying fee for such requested records is:

On disc: $6.50 disk fee
On paper: $5.00 labor fee, $1.00 per page for the first 25 pages, $0.50 per page thereafter
$15.00 Certification fee if requested

Requests for Release of Health Information not completed and witnessed at one of our facilities require a notarized validation of identity of the requestor.

Appeal Process

Step 1: You may report any complaint/grievance to any employee of AltaPointe. All complaints received will be reported to the Consumer Needs Specialist. You will receive a response with possible solutions to your complaint within 10 working days from the Consumer Needs Specialist.

Step 2: If you are not satisfied with the solution you may request that your complaint be reviewed by the Consumer Needs Committee. You will receive a response with a possible solution from the Consumer Needs Committee within 10 working days.

Step 3: If you are not satisfied with the solution offered by the Consumer Needs Committee you may request that your complaint be reviewed by the CEO of AltaPointe Health. You will receive a response from the CEO within 30 days.

At any time you may contact the following agencies regarding your complaint/grievance:

Department of Mental Health – Mental Retardation Office of Advocacy Services
1-800-367-0955

Alabama Disabilities Advocacy Program
1-800-826-1675

Consumer Needs Specialist
(251) 450-4303

Department of Human Resources
(251) 450-9100 (Children) or (251) 450-1800 (Adult)

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about ALTAPOINTE by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

AltaPointe Health
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We have a legal duty to safeguard your (PHI) Protected Health Information. This PHI includes information that can be used to identify you that we have created or reviewed about your past, present or future health conditions. It contains what healthcare we have provided to you, or the payment history on healthcare related accounts. We must provide you with notice about our privacy practices and explain how, when and why we use and disclose your PHI.

We will not use or disclose your health information without your authorization, except as described in this notice or otherwise required by law. We are legally required to follow the privacy practices that are described in this notice.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS:

The confidentiality of alcohol and drug abuse records maintained by this organization is protected by federal law and regulations. Generally, the program may not communicate to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser unless one of the following conditions is met:

* you consent to it in writing
* the disclosure is allowed by a court order
* the disclosure is made to medical personnel in a medical emergency or to qualified personnel for program

Violations of federal laws and regulations by a program are a crime. Suspected violations may be reported to the appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by you either at the program or against any person(s) who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

YOUR HEALTH INFORMATION RIGHTS:

Although your medical record is the physical property of AltaPointe Health, the information belongs to you. You have the right to:

* request in writing a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
* request in writing to obtain a paper copy of your health record as provided for in 45 CFR 164.524
* request in writing to amend your health record as provided in 45 CFR 164.526
* obtain a paper copy of the notice of information practices upon request
* request in writing to obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request in writing communication of your health information by alternative (other) means or at other locations
* revoke in writing your authorization to use and disclose health information except to the extent that action has already been taken
* obtain notice following any breach of your unsecured protected health information as provided in 45 CFR 164.520(b)(1)(v)(A)

OUR RESPONSIBILITIES:

AltaPointe Health is required to:

* maintain the privacy of your health information
* provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate health information by other means or at other locations
* train our personnel concerning privacy and confidentiality; implement a sanction policy to discipline those who breach privacy or confidentiality of our policy

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our Information practices change; the revised notice will be available through your therapist and in the lobby of the facility.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the Consumer Needs Specialist at 251-450-4303.
If you believe your privacy rights have been violated you can file a complaint with the Consumer Needs Specialist at AltaPointe Health or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Your written statement to AltaPointe Health and/or the Office of Civil Rights must include your name; address; telephone number; your signature; how, why, and when you believe you were discriminated against; name and address of institution or agency you believe discriminated against you; and any other relevant information.

You may submit in writing a request for review of any discrepancy or complaint under HIPAA to any of the following:

Director
Office of Civil Rights
U.S. Department of Health & Human Service
61 Forsyth St., SW – Suite 31370
Atlanta, GA 30323
(404) 562-7858 or 562-7884

Consumer Needs Department
AltaPointe Health
5750-B Southland Drive
Mobile, AL 36693
(251) 450-4303

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment (for example):
Information obtained by a, doctor, nurse or other mental health professional will be recorded in your record and used to determine the course of treatment that will work best for you. Any service provided to you will be documented in the record.

We will use your health information for payment (for example):
A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. You may request restrictions on such uses only if the request relates to services paid of out-of-pocket and the request is for nondisclosure to a health plan related solely to such services as provided in 45 CFR164.520(v)(1)(iv)(a) and 164.522(a)(1)(vi)

We will use your health information for regular health operations (for example):
Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Business Associates:
We provide some services through contracts with business associates. (Example: certain diagnostic tests).

Directory:
We do not have a directory that provides any information concerning your treatment here.

Notification:
We will not disclose any information to anyone about you without your written consent/authorization. Examples of uses or disclosures requiring your authorization include most disclosures of psychotherapy notes as provided in 45 CFR 164.520(b)(1)(ii)(E)

Comm*unication with Family:*
Only with your written authorization/consent will we disclose to a family member, another relative, a close friend, or any other person that you identify; health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Funeral Directors:
We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing/continuity of care:
We may contact you to provide appointment reminders or information about treatment alternatives that may be of interest to you.

Fund raising:
We will not contact you concerning any fund raising activities.

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarking surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:
We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
We may disclose your health information as required by law.

Correctional institution:
If you are an inmate of a correctional institution, we may disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement:
We may disclose your health information for law enforcement purposes as required by law or in response to a court order.

Health Oversight Agencies & Public Health Authorities:
By Federal law provisions your health information may be released provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more consumers, workers or the public.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (MEDICAL RECORDS) THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL HAVE THE REVISED NOTICE AVAILABLE IN THE THERAPIST'S OFFICE AS WELL AS HAVE A SUPPLY AVAILABLE IN THE LOBBY OF THE FACILITY.

EFFECTIVE DATE: **04/14/03**
Revised 4/23/2018
NB- 30

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR PSYCHIATRIC TELEHEALTH SERVICES

Patient Name: _____

Healthcare Practitioner: AltaPointe Health Credentialed Provider

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual consumer health information for the purpose of improving consumer care. **This consent is valid for twelve months.** The information obtained may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following:

- Live two-way audio and video
- Output data from medical devices and sound and video files

The interactive tele-video equipment and telecommunication lines used are HIPAA approved for consumer security and privacy.

Expected Benefits

- Improved access to psychiatric care by enabling a consumer to have a session with a psychiatrist while remaining at a remote site,
- More efficient medical evaluation and management.

Possible Risks

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment,
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of psychiatric information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to other entities without my written or verbal consent.
2. I have the right to withhold or withdraw my consent (either written or verbally) to the use of telehealth in the course of my care at any time.
3. I understand that the health care provider is off site at a remote location.
4. I understand that none of the teleconference will be recorded or photographed.
5. I understand that in the event of technical difficulties an employee of the IT department, as well as additional staff, may be present during my session.
6. I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
7. If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:_____
8. The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
9. I will be informed of all people who will be present at all sites during my telemedicine service.
10. I may exclude anyone from any site during my telehealth service.
11. I may see an appropriately trained staff person, or employee, in-person, immediately after the telemedicine service if an urgent need arises. **OR,** I will be told ahead of time that this is not available.
12. I may contact the healthcare provider at phone number _____ for any questions I have related to medical services received through a telemedicine provider/site.

I understand that this consent will expire on _____ (Twelve months from the signature date) **or** at the time of my discharge from this program, whichever comes first.

I have read this document carefully, and my questions have been answered to my satisfaction.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

OR Signature of Parent or Legal Representative: _____ Date: _____

Signature of Witness & Credentials/ Title Obtaining Telemedicine Consent: _____ Date: _____

MR#: EP: Date: – –
M M D D Y Y Y Y

ALTAPOINTE HEALTH, INC.
INFORMED CONSENT FOR
VERBAL / EMAIL EXCHANGE OF INFORMATION
SUBSTANCE ABUSE

I, _____ hereby consent to the verbal/ email exchange of information between
(Print consumer name)

AltaPointe Health and: _____
(Name of person or organization or email address information will be discussed with)

regarding_____
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (One year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Consumer Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

AltaPointe Health

Urine Drug Screen

Consumer Name: _____

I, the above consumer, agree to submit to testing, by AltaPointe Health; for urine drug screening.

I acknowledge that (check one): □*I am not taking medication*
□ *I am taking the following medication(s)*: _____

_____

Consumer Signature_____ Date_____

Witness Signature _____ Date_____

(Renewal needed with each new episode of SA treatment provided)

Revised 3/7/2018 BC 92089

92089

MR#: EP: Date: M M – D D – Y Y Y Y

ALTAPOINTE HEALTH
MEDICATION ASSISTED DRUG TREATMENT PROGRAM

INFORMED CONSENT FOR BLOOD and URINE COLLECTION AND TB SKIN TEST

Consumer Name _____

By my signature below, I understand that to be accepted in the Drug Abuse Treatment and Rehabilitation program, I must agree to:

_____ Initials — Submit to a Breathalyzer when clinically indicated.

_____ Initials — Provide blood samples upon request for the purpose of detecting Hepatitis C.

_____ Initials — Provide urine sample upon request for the purpose of analysis

_____ Initials — Submit to a TB skin test or chest x-ray for the purpose of detecting Tuberculosis.

_____ Initials — Submit to blood sample for liver function tests (Hepatic panel).

I understand that if I fail to comply with this agreement, I can be terminated from the program.

_____ _____
Consumer's Signature Date

_____ _____
Witness' Signature Date

BC91016
Revised 11/1/2017

91016

4211 Government Boulevard
Mobile, Al 36693

Date: _____

MR#: _____

I, _____ declare I cannot meet the expense for medication assisted drug treatment services (Methadone or Suboxone CURES) rendered by AltaPointe Health.

If, for whatever reason, I am discharged and re-apply to the program, I will be required to re-apply for financial assistance. I understand that this does not apply to any other services received at any other AltaPointe Health, BayView Professional Associates or Accordia Health Location.

_____ _____

Consumer's Signature Date

_____ _____

Witness' Signature Date

Created 10/8/2018
NB-120

AltaPointe Health

Financial Assistance Application Instructions

Consumers who are unable to pay for services at any of the AltaPointe Health locations, with the exception of services rendered at Bayview Professional locations, may qualify for our financial assistance program. AltaPointe Health's Financial Assistance Program will cover all or a portion of the cost of care you receive. The amount of Financial Assistance received can range from 100% to 10% and is based on the federal poverty guidelines.

To be considered for Financial Assistance with AltaPointe Health you must complete the attached application and provide one of the following to satisfy the proof of income requirement:

- Most Recent Income Tax Form Signed, W-2(s), 1099, 1040
- 2 Pay Stubs
- Proof of Social Security income, if applicable
- Verification letter if receiving Food Stamps
- Proof of Family Planning Only, Medicaid
- Proof of alimony, child support, unemployment, pension, etc.
- If you receive no income and are being supported by relatives or friends, a notarized letter explaining those arrangements is required. The letter must be signed by person(s) lending assistance.
- A letter from physician if unable to work

Once your application is completed, please return it and your proof of income documentation to any AltaPointe Health location or mail it to:

AltaPointe Health
5750-A Southland Drive
Mobile, AL, 36693

AltaPointe Health will review your application to determine the level of assistance for which you are eligible. Once a decision is made, a letter will be sent via mail notifying you of approval or denial of the financial assistance application. If approved, the level of financial assistance received will be based on the Federal Poverty Guidelines.

If approved, the financial assistance application will be good for one calendar year. The discounted amount will be valid at all AltaPointe Health locations, with the exception of Bayview Professional locations. You will also be expected to inform AltaPointe Health if there are any changes in your financial situation in the upcoming calendar year that may impact your eligibility for financial assistance. If you need any assistance with the Financial Assistance Application process, please contact by phone at (251)450-5916.

AltaPointe Health

Financial Assistance Application

Patient Information:

Name:_____ DOB:____/____/____
(Last) (First) (MI) (MM/DD/YYYY)

Address:_____
(Street/Apt Number) (City) (State) (Zip)

Social Security Number: _____ Telephone Number: (___)_____ (___)_____
(Home) (Cell)

Parent/Guardian Information 1:

Name:_____ DOB:____/____/____
(Last) (First) (MI) (MM/DD/YYYY)

Address:_____
(Street/Apt Number) (City) (State) (Zip)

Relationship to Patient: _____ Telephone Number: (___)_____ (___)_____
(Home) (Cell)

Parent/Guardian Information 2:

Name:_____ DOB:____/____/____
(Last) (First) (MI) (MM/DD/YYYY)

Address:_____
(Street/Apt Number) (City) (State) (Zip)

Relationship to Patient: _____ Telephone Number: (___)_____ (___)_____
(Home) (Cell)

Household (List all persons living in the household):

	Name	Relationship	Age	Annual Income:
1				
2				
3				
4				
5				
6				
7				
8				

AltaPointe Health

Income (Please provide the income for each of the following persons in your household):

Source	Patient/Guardian	Spouse	Other
Self Employment	_____	_____	_____
AFDC Benefits	_____	_____	_____
Food Stamps	_____	_____	_____
Social Security/Disability	_____	_____	_____
Unemployment Compensation	_____	_____	_____
Child Support	_____	_____	_____
Alimony	_____	_____	_____
Pensions/Interest/Rental/ Dividends Income	_____	_____	_____
Other Sources	_____	_____	_____
		Total House Income:	_____

I hereby request that AltaPointe Health make a written determination of my eligibility for reduced fee services.

I understand that the information, which I submit concerning my annual income and household/family size, is subject to verification by this organization and subject to review by state and/or federal enforcement agencies and others as required. I understand that the information given within this document is for the purpose of determining eligibility for financial assistance and that false or incomplete information will result in my disqualification for financial assistance.

If my financial situation changes in the upcoming calendar year I will report these changes to AltaPointe Health immediately.

Print Name: _____

Signature of Responsible Party: _____ Date signed: _____

For Finance and Accounting Use Only:

Date Received: ____/___/____ Approved ☐ Denied ☐

Reviewed by: _____

Reason for Denial: _____

_____

Percentage Approved: _____%