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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Information** | | | | | | | | | | | | | | | |
| Client Name: | | | | | | | | Date: | | | | | | | |
| Cell Number: | | | | | | | | Land Line/Message: | | | | | | | |
| What is you preferred method of communication? IF by text, be advised you will need to download a free app that allows us to send texts through a secure provider; however, still try not to send any Protected Health Information if at all possible. Please check one:  I prefer to communicate by text Yes [ ] No [ ] Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please be advised that if you chose to send an email and do **not** have a Google address, your email may not be secure. Please sign here that you understand that. Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| DOB: |  | Age: | | Sex: | | | | Social Security Number: | | | | | | | |
| Mailing Address: | | | | | | | City: | | | | | State: | | Zip: | |
| Living Arrangements: | | |  | | | | | | | | | | Marital Status: | |  |
| Workplace/School: | | | | | | | | | Occupation: | | | | | | |
| Work/School Address: | | | | | | | | | Phone Number: | | | | | | |
| If attending school, where? | | | | | | | | | | | | | | | |
| **Parent/Guardian Information (If client is a minor) & Client’s Emergency Contact** | | | | | | | | | | | | | | | |
| Parent(s) Names: | | | | | | | | | | | | | | | |
| Phone Number: | | | | | Home: | | | | | | | Work: | | | |
| Mailing Address: | | | | | | | City: | | | | | State: | | Zip: | |
| Emergency Contact: | | | | | | | | | | | | | | | |
| Phone Number: | | | | | Home: | | | | | | | Work: | | | |
| Mailing Address: | | | | | | | City: | | | | | State: | | Zip: | |
| **Medical Information** | | | | | | | | | | | | | | | |
| Primary Physician: | | | | | | | | Phone Number: | | | | | | | |
| Address: | | | | | | | | Primary Diagnosis: | | | | | | | |
| Medication: | | | | | | | | Allergies: | | | | | | | |
| Special Dietary/Medical Needs: | | | | | | | | | | | | | | | |
| Infectious Diseases: | | | | | | | | If yes, what treatment is/was used? | | | | | | | |
| Psychiatrist/Psychologist: | | | | | | | | | | Phone Number: | | | | | |
| Address: | | | | | | | | | | | | | | | |
| **If you do not have a primary care provider, please be advised that you are being asked, as part of the intake process, to set that up and provide us with that information once established. I have read and understand that I am being referred to seek a medical provider:** Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Do you have an advanced directive? Yes [ ] No [ ] Would you like one? Yes [ ] No [ ] If yes, be advised there is one included in this packet for you. We would like a copy once it is filled out so that we are honoring your wishes in the unlikely event that something happens while you are with us. I have taken one and will provide you a copy. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **Service Information** | | | | | | | | | | | | | | | |
| Service Requested: | | | | | | | | | | | | | | | |
| Court Order: [ ] Yes [ ] No | | | | | | County: | | | | | Referred by: | | | | |
| **Payment Information/Agreement** | | | | | | | | | | | | | | | |
| [ ] Private Pay [ ] Medicaid #: [ ] Private Insurance/Group/Member #: | | | | | | | | | | | | | | | |
| **I will be responsible for all costs incurred for treatment that are not covered by insurance. I understand that some costs may change if I lose my benefits, benefits/co-pays change, or billing issues delay New Beginnings being aware of fees that I am ultimately responsible for. In any case, I will be responsible for payment whenever costs develop.** Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Brief Explanation for Need of Service** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |

Specifications Sheet

The following information will help us serve you better. This information will be kept confidential.

Are you a student? \_\_\_\_\_\_\_ Current Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to New Beginnings Counseling and Support Services (NBCSS) by

(Please circle): Self Friend Family Web site

Facebook Radio TV Social Worker Court Services

Social Services Agency Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle all that apply: \*African American or Black \*Asian American

\*Native American/First Nation \*White/Caucasian \*Hispanic or Latino

\*Native Hawaiian or Other Pacific Islander \*Other-Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Do you have a physical disability that would help us understand and serve you better? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

So that we can best serve you, have you ever been told that you have a learning disability? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check below your reasons for wanting to see a counselor (mark all that apply):

\_\_\_\_\_\_\_I have some personal problems/issues/feelings I’d like to discuss

\_\_\_\_\_\_\_I am having trouble in school and I need help

\_\_\_\_\_\_\_I have suffered a loss and I need help to get me through

\_\_\_\_\_\_\_I need help managing the diagnosis I have been given

­­­­­­­\_\_\_\_\_\_\_I may need help with a substance use issue

**Criminal/Civil Court History**

***This in no way affects services, the information is for the use of this agency and is strictly to understand your circumstances.***

Have you been involved in any civil lawsuits, or are you involved in one now?

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested? If so, please describe:

\*Arrested for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convicted of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently on probation/parole for this crime? No\_\_ Yes\_\_ Until When \_\_\_\_\_\_\_\_\_ If you were ever on probation/parole for this crime, it was between the dates of:

Began\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Arrested for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convicted of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently on probation/parole for this crime? No\_\_ Yes\_\_ Until When \_\_\_\_\_\_\_\_\_ If you were ever on probation/parole for this crime, it was between the dates of:

Began\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Arrested for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convicted of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently on probation/parole for this crime? No\_\_ Yes\_\_ Until When \_\_\_\_\_\_\_\_\_ If you were ever on probation/parole for this crime, it was between the dates of:

Began\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for better helping us understand your circumstances!

**Signature Pages & Verification**

**That Client Has Been Provided All Documents**

**I have been given an exact, full size copy of each of the following documents for my own records and am signing below that I have received all of them.**

**Client’s Name**

**Client/Guardian Signature Date**

**Witness Signature Date**

**INFORMED CONSENT FORM**

I understand that…

**The areas of focus could include social, housing, legal/community, family, basic living skills, educational/vocational, and medical. The services can be provided in the home, community and office setting depending on the individual’s circumstance.**

* Treatments I receive will be explained to me in advance, and I will have the right to consent to any treatment or to decline.
* I have the right to terminate service at any time for any reason.
* If I do not believe I am receiving the help I need to develop the means to solve my problems and overcome obstacles that every effort will be made to find alternatives for treatment.
* The contents of my sessions and plans for treatment will be kept confidential except that:
  + They may be revealed in supervision or in consultation within the agency;
  + Any intent to harm another person will be reported to the proper authorities, and if possible, to the person threatened;
  + Any intent to harm myself will be reported to the proper authorities;
  + They may be revealed to persons or agencies as agreed by me in writing.
* I have the right to contact the Health & Welfare or Optum if I am dissatisfied with services.
* I have the right to select another provider, even after assessment is completed.
* **Risks of services are, but not limited to: Increase of symptoms, mental health services are not a guarantee to completely help with everything, there will be times that feelings of uncomfortableness may arise based on the seriousness of symptoms, services are not for everyone, this might not be an effective approach of services for you.**
* **Benefits of services are, but not limited to: Decrease in symptoms, increase independent functioning, developing and implementing coping skills for day to day life, increase in accessing more natural supports, increase of own self-awareness in dealing with symptoms.**

**Education for participants and family: NBCSS may offer referrals for Participant and Family to other behavior providers, Med Management doctors, education in the form of Web Site information, or other such services to assist Participant/Families achieve the most of the services being provided.**

I have read this informed consent form, I understand my rights, and what the risks and benefits are for receiving services.

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**COMMUNICABLE DISEASE TESTING**

Many individuals entering recovery or counseling services have been exposed to

persons, places or objects which may have exposed them to the following:

-Tuberculosis (TB)

-HIV, the AIDS virus

-Sexually Transmitted Diseases

-Hepatitis A, B, and/or C

We recommend our clients be tested for the above communicable diseases. You

may be tested for each of these at either no cost or low cost to you at the following location(s):

-Tri State Memorial Hospital

-Idaho Health Department

-Valley Medical Center

-Primary physician

\*Please let your clinician know if you have a communicable disease so that our clients and staff remain safe and healthy

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**AGENCY CHOICE FORM**

I, have been provided with a list of current providers available to choose from. I am making the choice to have services provided through New Beginnings Counseling and Support Services.

­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**CONFIDENTIALITY AGREEMENT**

**WHY:**

To Safeguard private information about consumers or fellow employees

**WHO IS BOUND BY OUR CONDFIDENTIALITY POLICIES:**

Everyone who has access to our individuals, families, staff or their records

**WHAT YOU CAN SAY:**  
Nothing without a signed release of information

**WHAT YOU CAN’T DO:**

Do not release other entity written evaluations/information to another agency or person.

**WHO CAN YOU TALK TO:**

You can discuss a consumer with other staff members in a private, professional setting and with outside professionals who are also bound by similar confidentiality requirements, ie.: Voc. Rehab., DDP, FACS, etc… and with whom we have a release to share information.

**HOW ABOUT PHONE OR PERSONAL REQUESTS:**

All requests for detailed information will require a “written request to release information.” Be extremely cautious when discussing anyone over the phone. Be certain of the person to whom you are speaking.

**EXCEPTIONS TO THE CONFIDENTIALITY RULES:**

1. Bona fide medical emergency.
2. Imminent threat of physical harm.
3. Agency evaluations by State of Idaho with signed releases from Health and Welfare.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**CONFLICT OF INTEREST AGREEMENT**

*(A situation in which an agency or person directly or indirectly influences or appears to influence the direction of a participant to other services for financial gain.)*

New Beginnings Counseling and Support Services maintains the responsibility to all participants to ensure and promote the right to self-determination and to preserve the participant’s freedom to choose services and providers. Service Providers are to inform the participant, and/or the participant’s parent/guardian when a real or potential conflict of interest arises. All providers will ensure the protection of every participant’s right to freedom of choice in all aspect of their care; as well, all service coordinators will hold the participant’s interests in primary regard.

I have been informed of my client rights and that I have the right to refuse services and to choose my providers. I have been provided a list of available Agencies and choose the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**24/7 CLIENT COVERAGE**

New Beginnings Counseling and Support Services is to provide 24/7 coverage for each client. Each client will be given their worker’s cell phone number, in the event of an emergency. All workers cover their clients 24/7, if your worker is out of town at any time, he/she will organize coverage with another worker from New Beginnings Counseling and Support Services he/she will give you that person’s contact details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**MANDATORY REPORTING FORM**

New Beginnings Counseling and Support Services is concerned with the health and well-being of our clients and their families. Service providers are required to report any concerns about health and safety to the appropriate governing agency and to the Department. We maintain strict confidentiality in reference to our clients but cannot allow any abuse, whether witnessed or reported to go unreported to the proper authorities. We are mandated reporters for any type of abuse committed. Listed below are lists of some of the acts of abuse we will report:

* Suicidal acts, feelings, and Ideations
* Homicidal acts, feelings, and Ideations
* Any abuse of any child or adult

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**PERMISSION FORM**

At times it may be necessary for your teen who is in substance use disorder treatment to watch a documentary or movie that is related to recovery but that also may be rated R. This form gives NBCSS permission for your teen who is not of age to consent, that consent.

Sometimes we may have an extra group that is strictly just for clean and sober fun. I also give permission for NBCSS to play an appropriate movie that may also be rated R.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name

Client/Guardian Signature Date

Witness Signature Date

**HIPAA COMPLIANCE PROGRAM**

Notice of Privacy Practices

1. **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.**
2. **Our Duty to Safeguard Your Protected Health Information**.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (PHI). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new Notice at all Practice locations. You may request a copy of the new notice from the Practice HIPAA Project Office.

1. **How We May Use and Disclose Your Protected Health Information.**

We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment or our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we be permitted to make some uses/disclosures without your consent or authorization. The following offers more description and some examples of our potential uses/disclosures of your PHI.

**Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations**

Generally, we may use or disclose your PHI as follows:

**For Treatment**: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, or with our central pharmacy staff. Your PHI may also be shared with outside entities performing ancillary services relating to your treatment, such as lab work or x-rays, or for consultation purposes, or coordination of your care.

**To obtain payment:** We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may contact your employer to verify employment status, and/or release portions of your PHI to a private insurer to be paid for services that we delivered to you.

**For health care operations:** We may sue/disclose your PHI in the course of operating our clinical laboratory. For example, we may take your photograph for medication identification purposes, use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.

**Appointment reminders:** Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

**Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorization can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

**Uses and Disclosures of PHI from Mental Health Records Not Requiring Consent or Authorization:** The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

**When required by law:** We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

**Form public health activities:** We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

**For health oversight activities:** We may disclose PHI to an agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

**Relating to descendants:** We may disclose PHI relating to an individual’s death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

**For research purposes:** In certain circumstances, and under supervision of a privacy board, we may disclose PHI to our research staff and their designees in order to assist in medical research.

**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

**For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

**Uses and Disclosures of PHI from Alcohol and Other Drug Records Not Requiring [Consent or] Authorization:** The law provides that we may use/disclose you PHI from alcohol and other drug records without consent or authorization in the following circumstances:

**When required by law:** We may disclose PHI when a law requires that we report information about suspected chilled abuse and neglect, or when a crime has been committed on the program premises or against program personnel, or in response to a court order.

**Relating to descendants:** We may disclose PHI relating to an individual’s death if state or federal law requires the information for collection of vital statistics or inquiry into cause of death.

**For research, audit or evaluation purposes:** In certain circumstances, we may disclose PHI for research, audit or evaluation purposes.

**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement when a threat is made to commit a crime on the program premises or against program personnel.

**Uses and Disclosures Requiring You to have an Opportunity to Object**: In the following situations, we may disclose a limited amount of your PHI if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

**Patient Directories**: Your name, location, and general condition may be put into our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religious affiliation may be shared with clergy.

**To families, friends or others involved in your care:** We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

1. **Your Rights Regarding Your Protected Health Information. You have the following rights relating to your protected health information:**

**To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

**To choose how we contact you:** You have the right to ask that we send you information at an alternative address or by and alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

**To inspect and copy your PHI:** Unless you access is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

**To request amendment of your PHI:** If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or added to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (i) correct and complete; (ii) not created by us and/or not part of our records, or; (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to you PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

**To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family, or the facility directory; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

To receive this notice: You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

1. **How to Complain about our Privacy Practices:**

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Sections VI. below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington D.C. 20201. We will take no retaliatory action against you if you make such complaints.

1. **Contact Person for Information, or to Submit a Complaint:**

If you have questions about this Notice or any complaints about our privacy practices, please contact:

HIPAA Officer: Stephanie Beidman

Phone: 208-746-7661

Email: newbeginningslewistonidaho@gmail.com

1. Effective Date: This Notice was effective on April 14, 2003
2. Acknowledgement: I have received a copy of this Notice

Client’s Name

Date

Client/Guardian Signature

Date

Witness Signature

**HIPAA COMPLIANCE PROGRAM/ “NOTICE OF PRIVACY PRACTICES”**

**Consent To Use And Disclose Your Health Information**

This form is an agreement between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and New Beginnings Counseling and Support Services. When the word “you” is used below, it will mean your child, relative, or other person if you have written his or her name below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

When New Beginnings Counseling and Support Services examines, diagnoses, treats, or refers you, we will be collecting Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. If required, also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

The notice of privacy practices explains in more detail your rights and how we can use and share your information. Please read the notice before you sign this consent. By signing this form, you are agreeing to let us use your information here and with authorization send it to others.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our office, by calling us, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this “consent to use and disclose your health information” form, you have the right to revoke it (by writing a letter telling us you no longer wish us to use this information) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information.

**If you do not sign this consent form agreeing to what is in our “Notice of Privacy Practices” we cannot treat you.**

Client’s Name

Date

Client/Guardian Signature

Date

Witness Signature/Authority as the Personal Representative giving a copy of the “Notice of Privacy Practices” to Client/Guardian

**NOTICE OF ADMINISTRATIVE APPEAL RIGHTS**

You are encouraged to first discuss your concerns with the Supervisor of New Beginnings Counseling and Support Services. If this does not resolve your concerns, then, you have the right to pursue an administrative appeal of any decision made by New Beginnings Counseling and Support Services. This includes but is not limited to: (1) any decision to deny services or to discontinue planned services; (2) Department failure to act upon a referral or request for services within thirty (30) days. To begin an appeal, please contact: Hearings Coordinator Optum Idaho 205 East Water Tower Lane, Meridian, ID 83642

You may also be eligible for free legal assistance through **Idaho Legal Aid Services, Inc.** Their area offices and telephone numbers are:

|  |
| --- |
| **Idaho Legal Aid Services, Inc.** |
| PO Box 1683, 310 N 5th St, Boise ID 83701; 208-345-0106 |
| PO Box 1116, 708 Main St, 2nd Fl, Caldwell, ID 83606; 208-454-2591 |
| PO Box 973, 633 Main St, Lewiston, ID 83501; 208-743-1556 |
| PO Box 1296, 475 Polk St, Twin Falls, ID 83301; 208-743-7024 |
| 482 Constitution Way, Suite 101, Idaho Falls, ID 83402; 208-524-3660 |
| PO Box 1785, 150 S. Arthur, Suite 203, Pocatello, ID 83204; 208-233-0079 |
| PO Box 1439, 410 Sherman Av, Suite 303, Coeur d’Alene, ID 83814; 208-667-9559 |

For additional assistance, contact **Comprehensive Advocacy, Inc. (Co-Ad)** at

1-800-632-5125. Their area offices and telephone numbers are:

|  |
| --- |
| **Comprehensive Advocacy, Inc. (Co-Ad)** |
| 4477 Emerald, Suite B-100, Boise, ID 83706; 208-336-5353 |
| 845 Center, Suite 107, Pocatello, ID 83204; 208-233-0922 |
| 107 E 4th St, Moscow, ID 83842; 208-882-0962 |

**I .2.** Ensuring participants served by the Agency are not unduly subjected to risk through exposure to such individuals that appear at the Agency for any reason.

**J. Requirements for Assessments and Evaluations.**

Providers agree that all psychological and sociological evaluations shall be appropriate to the Standard of Care in Idaho, and all testing and evaluation instruments shall have supportive evidence of their validity and reliability. Further, Providers shall adhere to requirements set by or adopted by the Department for standards and guidelines for any and all assessments or evaluation of any sort.

**K. Insurance.**

**K-1. Commercial General Liability** The Provider shall obtain, at the Provider’s expense, and keep in effect during the term of this contract, Commercial General Liability (CGL) Insurance covering bodily injury and property damage. This insurance shall include personal injury liability coverage; blanket contractual liability coverage for the indemnity provided under this contract and products/completed operations liability. The combined single limit per occurrence shall not be less than $1,000,000.00 or the equivalent. Each annual aggregate limit shall not be less than $2,000,000.00, when applicable, and will be endorsed to apply separately to each job site or location.

**K-2 Professional Liability Insurance.** The Provider shall ensure that each of its employees who bill for Medicaid reimbursable services shall obtain and keep in effect during the entire term of the contract at their own expense or at the expense of the Provider, Professional Liability Insurance covering any damages caused by an error, omission or any negligent acts. The combined single limit per occurrence shall not be less than $1,000,000, or the equivalent. The annual aggregate limit shall not be less than $2,000,000.

The PROVIDER understands and agrees that violation of any of the terms and conditions of this Additional Terms or the MEDICAID PROVIDER ENROLLMENT AGREEMENT constitutes sufficient grounds for termination of this agreement and may be grounds for disciplinary action as provided by rules or statute.

If you have any questions regarding the notice or any complaints about our privacy practices, please contact:

New Beginnings Counseling and Support Services Supervisor on (208-746-7661).

Acknowledgement: I have received a copy of the Appeal Rights Notice.

Client’s Name

Date

Client/Guardian Signature

Date

Witness Signature

**PARTICIPANT RIGHTS AND RESPONSIBILITIES**

You have rights. You have the same rights as everyone else, including some that are specific to your services through New Beginnings Counseling and Support Services. As a participant at NBCSS, you also have responsibilities in reference to your treatment. A NBCSS staff member will explain the following rights and responsibilities to you. If you have any questions, please ask them. It is our policy that the, “safety, welfare and human and civil rights of participants are adequately protected.” In addition to human and civil rights, participant rights will be protected.

**Participant Rights**

1. Humane care and treatment; and
2. Not be put in isolation; and
3. Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others; and
4. Be free of mental and physical abuse; and
5. Communicate by telephone or otherwise and to have access to private area to make telephone calls and receive visitors; and
6. Receive visitors at all reasonable times and to associate freely with persons of his own choice; and
7. Voice grievances and to recommend changes in policies or services being offered; and
8. Practice his own religion; and
9. Wear his own clothing and to retain and use personal possessions; and
10. Be informed of his medical and habilitative condition, of services available at the agency and the charges for the services; and
11. Reasonable access to all records concerning himself; and
12. Refuse services; and
13. Exercise all civil rights, unless limited by a prior court order.

1. Additional Participant Rights. The agency must also ensure the following rights:
2. Privacy and confidentiality; and
3. Be treated in a courteous manner; and
4. Receive a response from the agency to any request made within a reasonable time frame;
5. Receive services which enhance the participant’s social image and personal competencies and, whenever possible, promote inclusion in the community; and
6. Refuse to perform services for the agency. IF the participant is hired to perform services for the agency the wage paid must be consistent with stat and federal law; and
7. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; and
8. All other rights established by law; and
9. Be protected from harm.

**Participant Responsibilities**

1. In addition to the rights listed above, every Member has the responsibility to:
2. Supply information (to the extent possible), that Optum and its network practitioners need in order to provide care
3. Follow plans and instructions for care that they have agreed on with his or her network practitioner • Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible
4. Keep scheduled appointments and actively participate in treatment

I have had these rights and responsibilities explained to me by a NBCSS staff member. In addition to a copy of this form, I have received a packet of information that outlines access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. It has also been explained to me.

Client’s Name

Date

Client/Guardian Signature

Date

Witness Signature

Procedure:

Participant and guardian are informed of participant rights verbally by worker. Participant and guardian are to be provided with a packet of information which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet will be written in easily understandable terms and be given upon the initiation of services. Participant rights are posted in the center near the restrooms.

If you have a complaint, grievance, or in any way feel that your rights have been violated we encourage you to contact our Director, Stephanie Beidman, and make a formal written complaint using the attached *Participant/Guardian Grievance Form*.

Their contact information:

Stephanie Beidman, LMSW

1313 G Street

Lewiston, ID 83501

P (208) 746-7661

F (208) 746-0811

Our Director will review your grievance and contact you via phone or in person regarding it within two (2) working days in order to assist in remedying the situation.

If you feel that your grievance can not be/is not satisfied in the above manner, please contact:

|  |  |  |
| --- | --- | --- |
| **OPTUM Idaho**  205 East Water Tower Lane Meridian, ID 83642  Phone: (855) 202-0973 | **Idaho State Health and Welfare, Lewiston**  2604 16th Ave. Lewiston, ID 83501  (208) 799 – 3460  (208) 799 - 4440 | If you are being abuse or suspect that your child is being abused:  Child Abuse And Neglect Reporting/24 Hour  Idaho State Health and Welfare, Lewiston  Bldg 1118 F Lewiston, ID 83501  (208) 799 – 4360 |

**EXAMPLE**

**Participant/Guardian Grievance Form**

Please fill out and turn this form into NBCSS Director, Stephanie Beidman.

Name of person completing report (please print):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am (circle one):

(A) Participant (B) Guardian, my son or daughter’s name is:

Grievance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What I would like to see done about it:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant/Guardian Grievance Form**

Director’s Response:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was participant/guardian(s) contacted via phone or in person within two (2) working days of receiving this report?

YES \_\_\_\_ NO \_\_\_\_

If no, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was grievance addressed and remedied?

YES \_\_\_\_ NO \_\_\_\_

If no, explain steps to be taken to do so:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RIGHTS FORM

A representative of New Beginnings Counseling and Support Services has explained the following to me in detail:

\_\_\_\_\_\_ I may refuse or terminate services at any time during the course of treatment.

\_\_\_\_\_\_ I have the right to be treated respectfully and to have my questions/concerns addressed in a timely manner.

\_\_\_\_\_\_ I have the right to receive services at the times that are convenient for me/my family.

\_\_\_\_\_\_ I was made aware there are other agencies that provide similar services and was offered a list of these agencies.

\_\_\_\_\_\_ I have the right to appeal the decision of NBCSS. If I have questions, I can contact the Optum Client’s Representative @ 855-202-0973. I can also call this number in the event of a grievance with the agency.

\_\_\_\_\_\_ I have been given the phone numbers and address of both local and state authorities in the event of an appeal or to raise concerns regarding my treatment or that of a child in my care.

\_\_\_\_\_\_ I have been made aware that I have the right to legal services, support in the event I have a grievance.

\_\_\_\_\_\_ I understand I can access emergency services in the event of a crisis by contacting the SRCS office at 208-746-7661 between the hours of 9:00am-5:00pm, or by calling the providers cell phone that will be provided to each client after hours for 24/7 coverage.

I have received and reviewed the following documents:

\_\_\_\_\_\_ The Participant Rights Form

\_\_\_\_\_\_ The Client Grievance Policy

By signing below, I acknowledge the above indicated issues have been explained in full and that I wish to select New Beginnings Counseling and Support Services as my treatment provider.

Client’s Name

Date

Client/Guardian Signature

Date

Witness Signature

Release of Information Checklist

The following three (3) forms are releases of information. The purpose of these forms is to allow the sharing of protected health information. Filling out releases at this time will prevent the hassle of needing you to come back into the office when designated people are requesting your information or you are requesting that your information be sent out. Below is a list of facilities/people that may be helpful to have a Release of Information form for.

* Primary Care Physician (Doctor)
* Juvenile Probation
* Family member
* Spouse
* Attorney
* Probation and Parole
* SUD Treatment Agencies
* DSHS
* Emergency Contact
* Health & Welfare
* Hospital
* Jenifer/ Sacajawea Junior High School
* LCSC/WWCC
* Lewiston/Clarkston High School
* Lincoln Middle School
* Mental Health Agencies
* Police Department
* Psychiatrist

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **New Beginnings Counseling and Support Services 1313 G Street; Lewiston, Idaho 83501 P:208-746-7661 F:208-746-0811** | | | | | | | | | | | | | | | | | | | | |
| **Section A Client Information** | | | | | | | | | | | | | | | | | | | | |
| Client Name | | |  | | | | | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | |
| Date of Birth | | |  | | | | | | Phone Number | | | | |  | | | | | | |
| **Section B Other Medical Practitioner/Behavioral Health Agency/Government Agency/Parent/Other Person** | | | | | | | | | | | | | | | | | | | | |
| Name | | Doctor: | | | | | | | | | | | | | | | | | | |
| Agency, If Applicable | | | | | | Office: | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | Fax | |  | | | | Phone | |  | |
| **Section C Information Being Requested or Authorized to Send** | | | | | | | | | | | | | | | | | | | | |
| **New Beginnings is requesting the following information about the client in Section A** | | | | | | | | | | | | | | | | | | | | |
|  | GAIN Assessment/Drug & Alcohol Assessment | | | | | | | | |  | | SUD Tx Plan | | | | | | | | |
|  | Psychiatric Evaluation | | | | | | | | |  | | Bio-Psycho-Social Eval/Med-Soc Hx | | | | | | | | |
|  | Mental Health Comp | | | | | | | | |  | | Mental Health Tx Plan | | | | | | | | |
|  | Medical History/ Last Physical, Dental, or Eye Exam | | | | | | | | |  | | Medication Records Past and Present/Rx’s and Reasons for Them, Dates Prescribed, Dosages, Refill Info | | | | | | | | |
|  | Court Related Information | | | | | | | | |  | | Probation/Parole Progress Reports | | | | | | | | |
|  | Admission/Discharge Summary | | | | | | | | |  | | Laboratory Results/Drug Testing | | | | | | | | |
|  | Case Management Plans/Progress | | | | | | | | |  | | School Records: | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
| **Section D The Above Information is Being Requested or Authorized to Send for the Following Purposes** | | | | | | | | | | | | | | | | | | | | |
|  | SUD Services | | | | | | | | |  | | Mental Health Services | | | | | | | | |
|  | Case Management | | | | | | | | |  | | HIV/AIDS Related Information | | | | | | | | |
|  | RSS Services | | | | | | | | |  | | Legal Services | | | | | | | | |
|  | Visitation Services | | | | | | | | |  | | DDA Services | | | | | | | | |
|  | CBRS/HI/BI/HS Services | | | | | | | | |  | | Coordination of Care for Client in Section A | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
| **Section E Legal Disclosure of Participant Rights to Confidentiality** | | | | | | | | | | | | | | | | | | | | |
| \*I may refuse to sign this form if I chose, without fear of this agency conditioning treatment, payment, enrollment or eligibility for benefits, unless allowed by law. I may request a copy of this form at any time.  \*I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  \*To the party receiving information from New Beginnings: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42) CFR Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose. | | | | | | | | | | | | | | | | | | | | |
| **Section F Consent of the Confidential Exchange of Information** | | | | | | | | | | | | | | | | | | | | |
| \*This consent is valid for One Year from the date signed but can be revoked at any time-either verbally or in writing, with the understanding that some information may have already been exchanged when and if a revocation is given.  I, the client specified in Section A, do hereby freely, voluntarily, and without coercion, authorize New Beginnings Counseling and Support Services and the agency or person in Section B, to release, exchange, and receive the information stipulated above in section C for the expressed purposes stipulated in Section D. | | | | | | | | | | | | | | | | | | | | |
| Client Signature | | | |  | | | | | | | | | | | Date |  | | | | |
| Guardian Signature | | | | |  | | | | | | | | | | Date |  | | | | |
| Signature of New Beginnings Representative | | | | | | | | |  | | | | | | Date |  | | | | |
| I Do *NOT* Want Information Shared With: | | | | | | | | | | | | | | | | | | | | |
| My PCP/Medical Practitioner(s) | | | | | | |  | My other Behavioral Health Provider(s) | | | | | | | | |  | Other: | |  |
| **New Beginnings Counseling and Support Services 1313 G Street; Lewiston, Idaho 83501 P:208-746-7661 F:208-746-0811** | | | | | | | | | | | | | | | | | | | | |
| **Section A Client Information** | | | | | | | | | | | | | | | | | | | | |
| Client Name | | |  | | | | | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | |
| Date of Birth | | |  | | | | | | Phone Number | | | | |  | | | | | | |
| **Section B Other Medical Practitioner/Behavioral Health Agency/Government Agency/Parent/Other Person** | | | | | | | | | | | | | | | | | | | | |
| Name | | Medicaid | | | | | | | | | | | | | | | | | | |
| Agency, If Applicable | | | | | | Medicaid | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | Fax | |  | | | | Phone | |  | |
| **Section C Information Being Requested or Authorized to Send** | | | | | | | | | | | | | | | | | | | | |
| **New Beginnings is requesting the following information about the client in Section A** | | | | | | | | | | | | | | | | | | | | |
|  | GAIN Assessment/Drug & Alcohol Assessment | | | | | | | | |  | | SUD Tx Plan | | | | | | | | |
|  | Psychiatric Evaluation | | | | | | | | |  | | Bio-Psycho-Social Eval/Med-Soc Hx | | | | | | | | |
|  | Mental Health Comp | | | | | | | | |  | | Mental Health Tx Plan | | | | | | | | |
|  | Medical History/ Last Physical, Dental, or Eye Exam | | | | | | | | |  | | Medication Records Past and Present/Rx’s and Reasons for Them, Dates Prescribed, Dosages, Refill Info | | | | | | | | |
|  | Court Related Information | | | | | | | | |  | | Probation/Parole Progress Reports | | | | | | | | |
|  | Admission/Discharge Summary | | | | | | | | |  | | Laboratory Results/Drug Testing | | | | | | | | |
|  | Case Management Plans/Progress | | | | | | | | |  | | School Records: | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: Coordination of Care | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
| **Section D The Above Information is Being Requested or Authorized to Send for the Following Purposes** | | | | | | | | | | | | | | | | | | | | |
|  | SUD Services | | | | | | | | |  | | Mental Health Services | | | | | | | | |
|  | Case Management | | | | | | | | |  | | HIV/AIDS Related Information | | | | | | | | |
|  | RSS Services | | | | | | | | |  | | Legal Services | | | | | | | | |
|  | Visitation Services | | | | | | | | |  | | DDA Services | | | | | | | | |
|  | CBRS/HI/BI/HS Services | | | | | | | | |  | | Coordination of Care for Client in Section A | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
| **Section E Legal Disclosure of Participant Rights to Confidentiality** | | | | | | | | | | | | | | | | | | | | |
| \*I may refuse to sign this form if I chose, without fear of this agency conditioning treatment, payment, enrollment or eligibility for benefits, unless allowed by law. I may request a copy of this form at any time.  \*I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  \*To the party receiving information from New Beginnings: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42) CFR Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose. | | | | | | | | | | | | | | | | | | | | |
| **Section F Consent of the Confidential Exchange of Information** | | | | | | | | | | | | | | | | | | | | |
| \*This consent is valid for One Year from the date signed but can be revoked at any time-either verbally or in writing, with the understanding that some information may have already been exchanged when and if a revocation is given.  I, the client specified in Section A, do hereby freely, voluntarily, and without coercion, authorize New Beginnings Counseling and Support Services and the agency or person in Section B, to release, exchange, and receive the information stipulated above in section C for the expressed purposes stipulated in Section D. | | | | | | | | | | | | | | | | | | | | |
| Client Signature | | | |  | | | | | | | | | | | Date |  | | | | |
| Guardian Signature | | | | |  | | | | | | | | | | Date |  | | | | |
| Signature of New Beginnings Representative | | | | | | | | |  | | | | | | Date |  | | | | |
| I Do *NOT* Want Information Shared With: | | | | | | | | | | | | | | | | | | | | |
| My PCP/Medical Practitioner(s) | | | | | | |  | My other Behavioral Health Provider(s) | | | | | | | | |  | Other: | |  |
| **New Beginnings Counseling and Support Services 1313 G Street; Lewiston, Idaho 83501 P:208-746-7661 F:208-746-0811** | | | | | | | | | | | | | | | | | | | | |
| **Section A Client Information** | | | | | | | | | | | | | | | | | | | | |
| Client Name | | |  | | | | | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | |
| Date of Birth | | |  | | | | | | Phone Number | | | | |  | | | | | | |
| **Section B Other Medical Practitioner/Behavioral Health Agency/Government Agency/Parent/Other Person** | | | | | | | | | | | | | | | | | | | | |
| Name | | Attorney/Probation: | | | | | | | | | | | | | | | | | | |
| Agency, If Applicable | | | | | | Office: | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | Fax | |  | | | | Phone | |  | |
| **Section C Information Being Requested or Authorized to Send** | | | | | | | | | | | | | | | | | | | | |
| **New Beginnings is requesting the following information about the client in Section A** | | | | | | | | | | | | | | | | | | | | |
|  | GAIN Assessment/Drug & Alcohol Assessment | | | | | | | | |  | | SUD Tx Plan | | | | | | | | |
|  | Psychiatric Evaluation | | | | | | | | |  | | Bio-Psycho-Social Eval/Med-Soc Hx | | | | | | | | |
|  | Mental Health Comp | | | | | | | | |  | | Mental Health Tx Plan | | | | | | | | |
|  | Medical History/ Last Physical, Dental, or Eye Exam | | | | | | | | |  | | Medication Records Past and Present/Rx’s and Reasons for Them, Dates Prescribed, Dosages, Refill Info | | | | | | | | |
|  | Court Related Information | | | | | | | | |  | | Probation/Parole Progress Reports | | | | | | | | |
|  | Admission/Discharge Summary | | | | | | | | |  | | Laboratory Results/Drug Testing | | | | | | | | |
|  | Case Management Plans/Progress | | | | | | | | |  | | School Records: | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
| **Section D The Above Information is Being Requested or Authorized to Send for the Following Purposes** | | | | | | | | | | | | | | | | | | | | |
|  | SUD Services | | | | | | | | |  | | Mental Health Services | | | | | | | | |
|  | Case Management | | | | | | | | |  | | HIV/AIDS Related Information | | | | | | | | |
|  | RSS Services | | | | | | | | |  | | Legal Services | | | | | | | | |
|  | Visitation Services | | | | | | | | |  | | DDA Services | | | | | | | | |
|  | CBRS/HI/BI/HS Services | | | | | | | | |  | | Coordination of Care for Client in Section A | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
| **Section E Legal Disclosure of Participant Rights to Confidentiality** | | | | | | | | | | | | | | | | | | | | |
| \*I may refuse to sign this form if I chose, without fear of this agency conditioning treatment, payment, enrollment or eligibility for benefits, unless allowed by law. I may request a copy of this form at any time.  \*I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  \*To the party receiving information from New Beginnings: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42) CFR Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose. | | | | | | | | | | | | | | | | | | | | |
| **Section F Consent of the Confidential Exchange of Information** | | | | | | | | | | | | | | | | | | | | |
| \*This consent is valid for One Year from the date signed but can be revoked at any time-either verbally or in writing, with the understanding that some information may have already been exchanged when and if a revocation is given.  I, the client specified in Section A, do hereby freely, voluntarily, and without coercion, authorize New Beginnings Counseling and Support Services and the agency or person in Section B, to release, exchange, and receive the information stipulated above in section C for the expressed purposes stipulated in Section D. | | | | | | | | | | | | | | | | | | | | |
| Client Signature | | | |  | | | | | | | | | | | Date |  | | | | |
| Guardian Signature | | | | |  | | | | | | | | | | Date |  | | | | |
| Signature of New Beginnings Representative | | | | | | | | |  | | | | | | Date |  | | | | |
| I Do *NOT* Want Information Shared With: | | | | | | | | | | | | | | | | | | | | |
| My PCP/Medical Practitioner(s) | | | | | | |  | My other Behavioral Health Provider(s) | | | | | | | | |  | Other: | |  |
| **New Beginnings Counseling and Support Services 1313 G Street; Lewiston, Idaho 83501 P:208-746-7661 F:208-746-0811** | | | | | | | | | | | | | | | | | | | | |
| **Section A Client Information** | | | | | | | | | | | | | | | | | | | | |
| Client Name | | |  | | | | | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | |
| Date of Birth | | |  | | | | | | Phone Number | | | | |  | | | | | | |
| **Section B Other Medical Practitioner/Behavioral Health Agency/Government Agency/Parent/Other Person** | | | | | | | | | | | | | | | | | | | | |
| Name | | Parent, if you choose to consent: | | | | | | | | | | | | | | | | | | |
| Agency, If Applicable | | | | | |  | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | Fax | |  | | | | Phone | |  | |
| **Section C Information Being Requested or Authorized to Send** | | | | | | | | | | | | | | | | | | | | |
| **New Beginnings is requesting the following information about the client in Section A** | | | | | | | | | | | | | | | | | | | | |
|  | GAIN Assessment/Drug & Alcohol Assessment | | | | | | | | |  | | SUD Tx Plan | | | | | | | | |
|  | Psychiatric Evaluation | | | | | | | | |  | | Bio-Psycho-Social Eval/Med-Soc Hx | | | | | | | | |
|  | Mental Health Comp | | | | | | | | |  | | Mental Health Tx Plan | | | | | | | | |
|  | Medical History/ Last Physical, Dental, or Eye Exam | | | | | | | | |  | | Medication Records Past and Present/Rx’s and Reasons for Them, Dates Prescribed, Dosages, Refill Info | | | | | | | | |
|  | Court Related Information | | | | | | | | |  | | Probation/Parole Progress Reports | | | | | | | | |
|  | Admission/Discharge Summary | | | | | | | | |  | | Laboratory Results/Drug Testing | | | | | | | | |
|  | Case Management Plans/Progress | | | | | | | | |  | | School Records: | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
| **Section D The Above Information is Being Requested or Authorized to Send for the Following Purposes** | | | | | | | | | | | | | | | | | | | | |
|  | SUD Services | | | | | | | | |  | | Mental Health Services | | | | | | | | |
|  | Case Management | | | | | | | | |  | | HIV/AIDS Related Information | | | | | | | | |
|  | RSS Services | | | | | | | | |  | | Legal Services | | | | | | | | |
|  | Visitation Services | | | | | | | | |  | | DDA Services | | | | | | | | |
|  | CBRS/HI/BI/HS Services | | | | | | | | |  | | Coordination of Care for Client in Section A | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
| **Section E Legal Disclosure of Participant Rights to Confidentiality** | | | | | | | | | | | | | | | | | | | | |
| \*I may refuse to sign this form if I chose, without fear of this agency conditioning treatment, payment, enrollment or eligibility for benefits, unless allowed by law. I may request a copy of this form at any time.  \*I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  \*To the party receiving information from New Beginnings: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42) CFR Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose. | | | | | | | | | | | | | | | | | | | | |
| **Section F Consent of the Confidential Exchange of Information** | | | | | | | | | | | | | | | | | | | | |
| \*This consent is valid for One Year from the date signed but can be revoked at any time-either verbally or in writing, with the understanding that some information may have already been exchanged when and if a revocation is given.  I, the client specified in Section A, do hereby freely, voluntarily, and without coercion, authorize New Beginnings Counseling and Support Services and the agency or person in Section B, to release, exchange, and receive the information stipulated above in section C for the expressed purposes stipulated in Section D. | | | | | | | | | | | | | | | | | | | | |
| Client Signature | | | |  | | | | | | | | | | | Date |  | | | | |
| Guardian Signature | | | | |  | | | | | | | | | | Date |  | | | | |
| Signature of New Beginnings Representative | | | | | | | | |  | | | | | | Date |  | | | | |
| I Do *NOT* Want Information Shared With: | | | | | | | | | | | | | | | | | | | | |
| My PCP/Medical Practitioner(s) | | | | | | |  | My other Behavioral Health Provider(s) | | | | | | | | |  | Other: | |  |
| **New Beginnings Counseling and Support Services 1313 G Street; Lewiston, Idaho 83501 P:208-746-7661 F:208-746-0811** | | | | | | | | | | | | | | | | | | | | |
| **Section A Client Information** | | | | | | | | | | | | | | | | | | | | |
| Client Name | | |  | | | | | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | |
| Date of Birth | | |  | | | | | | Phone Number | | | | |  | | | | | | |
| **Section B Other Medical Practitioner/Behavioral Health Agency/Government Agency/Parent/Other Person** | | | | | | | | | | | | | | | | | | | | |
| Name | | Counselor/Psychiatrist: | | | | | | | | | | | | | | | | | | |
| Agency, If Applicable | | | | | | Office: | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | Fax | |  | | | | Phone | |  | |
| **Section C Information Being Requested or Authorized to Send** | | | | | | | | | | | | | | | | | | | | |
| **New Beginnings is requesting/supplying the following information about the client in Section A** | | | | | | | | | | | | | | | | | | | | |
|  | GAIN Assessment/Drug & Alcohol Assessment | | | | | | | | |  | | SUD Tx Plan | | | | | | | | |
|  | Psychiatric Evaluation | | | | | | | | |  | | Bio-Psycho-Social Eval/Med-Soc Hx | | | | | | | | |
|  | Mental Health Comp | | | | | | | | |  | | Mental Health Tx Plan | | | | | | | | |
|  | Medical History/ Last Physical, Dental, or Eye Exam | | | | | | | | |  | | Medication Records Past and Present/Rx’s and Reasons for Them, Dates Prescribed, Dosages, Refill Info | | | | | | | | |
|  | Court Related Information | | | | | | | | |  | | Probation/Parole Progress Reports | | | | | | | | |
|  | Admission/Discharge Summary | | | | | | | | |  | | Laboratory Results/Drug Testing | | | | | | | | |
|  | Case Management Plans/Progress | | | | | | | | |  | | School Records: | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
| **Section D The Above Information is Being Requested or Authorized to Send for the Following Purposes** | | | | | | | | | | | | | | | | | | | | |
|  | SUD Services | | | | | | | | |  | | Mental Health Services | | | | | | | | |
|  | Case Management | | | | | | | | |  | | HIV/AIDS Related Information | | | | | | | | |
|  | RSS Services | | | | | | | | |  | | Legal Services | | | | | | | | |
|  | Visitation Services | | | | | | | | |  | | DDA Services | | | | | | | | |
|  | CBRS/HI/BI/HS Services | | | | | | | | |  | | Coordination of Care for Client in Section A | | | | | | | | |
|  | Other: | | | | | | | | |  | | Other: | | | | | | | | |
| **Section E Legal Disclosure of Participant Rights to Confidentiality** | | | | | | | | | | | | | | | | | | | | |
| \*I may refuse to sign this form if I chose, without fear of this agency conditioning treatment, payment, enrollment or eligibility for benefits, unless allowed by law. I may request a copy of this form at any time.  \*I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  \*To the party receiving information from New Beginnings: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42) CFR Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose. | | | | | | | | | | | | | | | | | | | | |
| **Section F Consent of the Confidential Exchange of Information** | | | | | | | | | | | | | | | | | | | | |
| \*This consent is valid for One Year from the date signed but can be revoked at any time-either verbally or in writing, with the understanding that some information may have already been exchanged when and if a revocation is given.  I, the client specified in Section A, do hereby freely, voluntarily, and without coercion, authorize New Beginnings Counseling and Support Services and the agency or person in Section B, to release, exchange, and receive the information stipulated above in section C for the expressed purposes stipulated in Section D. | | | | | | | | | | | | | | | | | | | | |
| Client Signature | | | |  | | | | | | | | | | | Date |  | | | | |
| Guardian Signature | | | | |  | | | | | | | | | | Date |  | | | | |
| Signature of New Beginnings Representative | | | | | | | | |  | | | | | | Date |  | | | | |
| I Do *NOT* Want Information Shared With: | | | | | | | | | | | | | | | | | | | | |
| My PCP/Medical Practitioner(s) | | | | | | |  | My other Behavioral Health Provider(s) | | | | | | | | |  | Other: | |  |

**Informed Consent Form**

I understand that…

**The areas of focus could include social, housing, legal/community, family, basic living skills, educational/vocational, and medical. The services can be provided in the home, community and office setting.**

* Treatments I receive will be explained to me in advance, and I will have the right to consent to any treatment or to decline.
* I have the right to terminate service at any time for any reason.
* If I do not believe I am receiving the help I need to develop the means to solve my problems and overcome obstacles that every effort will be made to find alternatives for treatment.
* The contents of my sessions and plans for treatment will be kept confidential except that:
  + They may be revealed in supervision or in consultation within the agency;
  + Any intent to harm another person will be reported to the proper authorities, and if possible, to the person threatened;
  + Any intent to harm myself will be reported to the proper authorities;
  + They may be revealed to persons or agencies as agreed by me in writing.
* I have the right to contact the Health & Welfare or Optum if I am dissatisfied with services.

YOUR COPY TO KEEP

* I have the right to select another provider, even after assessment is completed.
* **Risks of services are, but not limited to: Increase of symptoms, mental health services are not a guarantee to completely help with everything, there will be times that feelings of uncomfortableness may arise based on the seriousness of symptoms, services are not for everyone, this might not be an effective approach of services for you.**
* **Benefits of services are, but not limited to: Decrease in symptoms, increase independent functioning, developing and implementing coping skills for day to day life, increase in accessing more natural supports, increase of own self-awareness in dealing with symptoms.**

**Education for participants and family: NBCSS may offer referrals for Participant and Family to other behavior providers, Med Management doctors, education in the form of Web Site information, or other such services to assist Participant/Families achieve the most of the services being provided.**

I have read this informed consent form, I understand my rights, and what the risks and benefits are for receiving services.

Clients Name

Client/Guardian Signature Date

Witness Signature Date

**Communicable Disease Testing**

Many individuals entering recovery or counseling services have been exposed to

persons, places or objects which may have exposed them to the following:

-Tuberculosis (TB)

-HIV, the AIDS virus

-Sexually Transmitted Diseases

-Hepatitis A, B, and/or C

We recommend our clients be tested for the above communicable diseases. You

may be tested for each of these at either no cost or low cost to you at the following location(s):

-Tri State Memorial Hospital

-Idaho Health Department

-Valley Medical Center

-Primary physician

\*Please let your clinician know if you have a communicable disease so that our clients and staff remain safe and healthy.

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Clients Name

Client/Guardian Signature Date

Witness Signature Date

**Agency Choice Form**

I, have been provided with a list of

(Client’s Name)

current providers available to choose from. I am making the choice to have services

provided through New Beginnings Counseling and Support Services.

Clients Name

Client/Guardian Signature Date

Witness Signature Date

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**Confidentiality**

**WHY:**

To Safeguard private information about consumers or fellow employees

**WHO IS BOUND BY OUR CONDFIDENTIALITY POLICIES:**

Everyone who has access to our individuals, families, staff or their records

**WHAT YOU CAN SAY:**  
Nothing without a signed release of information

**WHAT YOU CAN’T DO:**

Do not release other entity written evaluations/information to another agency or person.

**WHO CAN YOU TALK TO:**

You can discuss a consumer with other staff members in a private, professional setting and with outside professionals who are also bound by similar confidentiality requirements, ie.: Voc. Rehab., DDP, FACS, etc… and with whom we have a release to share information.

**HOW ABOUT PHONE OR PERSONAL REQUESTS:**

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All requests for detailed information will require a “written request to release information.” Be extremely cautious when discussing anyone over the phone. Be certain of the person to whom you are speaking.

**EXCEPTIONS TO THE CONFIDENTIALITY RULES:**

1. Bona fide medical emergency.
2. Imminent threat of physical harm.
3. Agency evaluations by State of Idaho with signed releases from Health and Welfare.

Clients Name

Client/Guardian Signature Date

Witness Signature Date

**Conflict of Interest Agreement**

*(A situation in which an agency or person directly or indirectly influences or appears to influence the direction of a participant to other services for financial gain.)*

New Beginnings Counseling and Support Services maintains the responsibility to all participants to ensure and promote the right to self-determination and to preserve the participant’s freedom to choose services and providers. Service Providers are to inform the participant, and/or the participant’s parent/guardian when a real or potential conflict of interest arises. All providers will ensure the protection of every participant’s right to freedom of choice in all aspect of their care; as well, all service coordinators will hold the participant’s interests in primary regard.

I have been informed of my client rights and that I have the right to refuse services and to choose my providers. I have been provided a list of available Agencies and choose the following:

Clients Name

Date

Client/Guardian Signature

YOUR COPY TO KEEP

Date

Witness Signature

**24/7 Client Coverage**

New Beginnings Counseling and Support Services is to provide 24/7 coverage for each client. Each client will be given their worker’s cell phone number, in the event of an emergency.

All workers cover their clients 24/7, if your worker is out of town at any time, he/she will organize coverage with another worker from New Beginnings Counseling and Support Services he/she will give you that person’s contact details.

Clients Name

Client/Guardian Signature Date

YOUR COPY TO KEEP

Witness Signature Date

**Mandatory Reporting Form**

New Beginnings Counseling and Support Services is concerned with the health and well-being of our clients and their families. Service providers are required to report any concerns about health and safety to the appropriate governing agency and to the Department. We maintain strict confidentiality in reference to our clients but cannot allow any abuse, whether witnessed or reported to go unreported to the proper authorities. We are mandated reporters for any type of abuse committed. Listed below are lists of some of the acts of abuse we will report:

* Suicidal acts, feelings, and Ideations
* Homicidal acts, feelings, and Ideations
* Any abuse of any child or adult

Clients Name

Client/Guardian Signature Date

YOUR COPY TO KEEP

Witness Signature Date

**PERMISSION FORM**

At times it may be necessary for your teen who is in substance use disorder treatment to watch a documentary or movie that is related to recovery but that also may be rated R. This form gives NBCSS permission for your teen who is not of age to consent, that consent.

Sometimes we may have an extra group that is strictly just for clean and sober fun. I also give permission for NBCSS to play an appropriate movie that may also be rated R.

YOUR COPY TO KEEP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Name

Client/Guardian Signature Date

Witness Signature Date

**HIPAA COMPLIANCE PROGRAM**

Notice of Privacy Practices

1. **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.**
2. **Our Duty to Safeguard Your Protected Health Information**.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (PHI). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new Notice at all Practice locations. You may request a copy of the new notice from the Practice HIPAA Project Office.

YOUR COPY TO KEEP

1. **How We May Use and Disclose Your Protected Health Information.**

We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment or our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we be permitted to make some uses/disclosures without your consent or authorization. The following offers more description and some examples of our potential uses/disclosures of your PHI.

**Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations**

Generally, we may use or disclose your PHI as follows:

**For Treatment**: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, or with our central pharmacy staff. Your PHI may also be shared with outside entities performing ancillary services relating to your treatment, such as lab work or x-rays, or for consultation purposes, or coordination of your care.

**To obtain payment:** We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may contact your employer to verify employment status, and/or release portions of your PHI to a private insurer to be paid for services that we delivered to you.

**For health care operations:** We may sue/disclose your PHI in the course of operating our clinical laboratory. For example, we may take your photograph for medication identification purposes, use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.

**Appointment reminders:** Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

**Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorization can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

**Uses and Disclosures of PHI from Mental Health Records Not Requiring Consent or Authorization:** The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

**When required by law:** We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

YOUR COPY TO KEEP

**Form public health activities:** We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

**For health oversight activities:** We may disclose PHI to an agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

**Relating to descendants:** We may disclose PHI relating to an individual’s death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

**For research purposes:** In certain circumstances, and under supervision of a privacy board, we may disclose PHI to our research staff and their designees in order to assist in medical research.

**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

**For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

**Uses and Disclosures of PHI from Alcohol and Other Drug Records Not Requiring [Consent or] Authorization:** The law provides that we may use/disclose you PHI from alcohol and other drug records without consent or authorization in the following circumstances:

**When required by law:** We may disclose PHI when a law requires that we report information about suspected chilled abuse and neglect, or when a crime has been committed on the program premises or against program personnel, or in response to a court order.

**Relating to descendants:** We may disclose PHI relating to an individual’s death if state or federal law requires the information for collection of vital statistics or inquiry into cause of death.

**For research, audit or evaluation purposes:** In certain circumstances, we may disclose PHI for research, audit or evaluation purposes.

**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement when a threat is made to commit a crime on the program premises or against program personnel.

**Uses and Disclosures Requiring You to have an Opportunity to Object**: In the following situations, we may disclose a limited amount of your PHI if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

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**Patient Directories**: Your name, location, and general condition may be put into our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religious affiliation may be shared with clergy.

**To families, friends or others involved in your care:** We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

1. **Your Rights Regarding Your Protected Health Information. You have the following rights relating to your protected health information:**

**To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

**To choose how we contact you:** You have the right to ask that we send you information at an alternative address or by and alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

**To inspect and copy your PHI:** Unless you access is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

**To request amendment of your PHI:** If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or added to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (i) correct and complete; (ii) not created by us and/or not part of our records, or; (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to you PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

**To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family, or the facility directory; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

To receive this notice: You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

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1. **How to Complain about our Privacy Practices:**

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Sections VI. below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington D.C. 20201. We will take no retaliatory action against you if you make such complaints.

1. **Contact Person for Information, or to Submit a Complaint:**

If you have questions about this Notice or any complaints about our privacy practices, please contact:

HIPAA Officer: Stephanie Beidman

Phone: 208-746-7661

Email: Newbeginningslewistonidaho@gmail.com

1. Effective Date: This Notice was effective on April 14, 2003
2. Acknowledgement: I have received a copy of this Notice

Clients Name

Client/Guardian Signature Date

Witness Signature Date

**HIPAA COMPLIANCE PROGRAM/ “NOTICE OF PRIVACY PRACTICES”**

**Consent To Use And Disclose Your Health Information**

This form is an agreement between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and New Beginnings Counseling and Support Services. When the word “you” is used below, it will mean your child, relative, or other person if you have written his or her name below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

When New Beginnings Counseling and Support Services examines, diagnoses, treats, or refers you, we will be collecting Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. If required, also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

The notice of privacy practices explains in more detail your rights and how we can use and share your information. Please read the notice before you sign this consent. By signing this form, you are agreeing to let us use your information here and with authorization send it to others.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our office, by calling us, or from our privacy officer.

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If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this “consent to use and disclose your health information” form, you have the right to revoke it (by writing a letter telling us you no longer wish us to use this information) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.**

Clients Name

Date

Client/Guardian Signature

Date

Witness Signature/Authority as the Personal Representative giving a copy of the “Notice of Privacy Practices” to Client/Guardian

**NOTICE OF ADMINISTRATIVE APPEAL RIGHTS**

You are encouraged to first discuss your concerns with the Supervisor of New Beginnings Counseling and Support Services. If this does not resolve your concerns, then, you have the right to pursue an administrative appeal of any decision made by New Beginnings Counseling and Support Services. This includes but is not limited to: (1) any decision to deny services or to discontinue planned services; (2) Department failure to act upon a referral or request for services within thirty (30) days. To begin an appeal, please contact:

Hearings Coordinator

Optum Idaho

205 East Water Tower lane

Meridian, ID 83642

You may also be eligible for free legal assistance through **Idaho Legal Aid Services, Inc.** Their area offices and telephone numbers are:

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|  |
| --- |
| **Idaho Legal Aid Services, Inc.** |
| PO Box 1683, 310 N 5th St, Boise ID 83701; 208-345-0106 |
| PO Box 1116, 708 Main St, 2nd Fl, Caldwell, ID 83606; 208-454-2591 |
| PO Box 973, 633 Main St, Lewiston, ID 83501; 208-743-1556 |
| PO Box 1296, 475 Polk St, Twin Falls, ID 83301; 208-743-7024 |
| 482 Constitution Way, Suite 101, Idaho Falls, ID 83402; 208-524-3660 |
| PO Box 1785, 150 S. Arthur, Suite 203, Pocatello, ID 83204; 208-233-0079 |
| PO Box 1439, 410 Sherman Av, Suite 303, Coeur d’Alene, ID 83814; 208-667-9559 |

For additional assistance, contact **Comprehensive Advocacy, Inc. (Co-Ad)** at

1-800-632-5125. Their area offices and telephone numbers are:

|  |
| --- |
| **Comprehensive Advocacy, Inc. (Co-Ad)** |
| 4477 Emerald, Suite B-100, Boise, ID 83706 ; 208-336-5353 |
| 845 Center, Suite 107, Pocatello, ID 83204; 208-233-0922 |
| 107 E 4th St, Moscow, ID 83842; 208-882-0962 |

**I .2.** Ensuring participants served by the Agency are not unduly subjected to risk through exposure to such individuals that appear at the Agency for any reason.

**J. Requirements for Assessments and Evaluations.**

Providers agree that all psychological and sociological evaluations shall be appropriate to the Standard of Care in Idaho, and all testing and evaluation instruments shall have supportive evidence of their validity and reliability. Further, Providers shall adhere to requirements set by or adopted by the Department for standards and guidelines for any and all assessments or evaluation of any sort.

**K. Insurance.**

**K-1. Commercial General Liability** The Provider shall obtain, at the Provider’s expense, and keep in effect during the term of this contract, Commercial General Liability (CGL) Insurance covering bodily injury and property damage. This insurance shall include personal injury liability coverage; blanket contractual liability coverage for the indemnity provided under this contract and products/completed operations liability. The combined single limit per occurrence shall not be less than $1,000,000.00 or the equivalent. Each annual aggregate limit shall not be less than $2,000,000.00, when applicable, and will be endorsed to apply separately to each job site or location.

**K-2 Professional Liability Insurance.** The Provider shall ensure that each of its employees who bill for Medicaid reimbursable services shall obtain and keep in effect during the entire term of the contract at their own expense or at the expense of the Provider, Professional Liability Insurance covering any damages caused by an error, omission or any negligent acts. The combined single limit per occurrence shall not be less than $1,000,000, or the equivalent. The annual aggregate limit shall not be less than $2,000,000.

The PROVIDER understands and agrees that violation of any of the terms and conditions of this Additional Terms or the MEDICAID PROVIDER ENROLLMENT AGREEMENT constitutes sufficient grounds for termination of this agreement and may be grounds for disciplinary action as provided by rules or statute.

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If you have any questions regarding the notice or any complaints about our privacy practices, please contact:

New Beginnings Counseling and Support Services Supervisor on (208-746-7661).

Acknowledgement: I have received a copy of the Appeal Rights Notice.

Clients Name

Client/Guardian Signature Date

Witness Signature Date

**Participant Rights and Responsibilities**

You have rights. You have the same rights as everyone else, including some that are specific to your services through New Beginnings Counseling and Support Services. As a participant at NBCSS, you also have responsibilities in reference to your treatment. A NBCSS staff member will explain the following rights and responsibilities to you. If you have any questions, please ask them.

It is our policy that the, “safety, welfare and human and civil rights of participants are adequately protected.” In addition to human and civil rights, participant rights will be protected.

**Participant Rights**

1.

* Humane care and treatment; and
* Not be put in isolation; and
* Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others; and
* Be free of mental and physical abuse; and
* Communicate by telephone or otherwise and to have access to private area to make telephone calls and receive visitors; and

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* Receive visitors at all reasonable times and to associate freely with persons of his own choice; and
* Voice grievances and to recommend changes in policies or services being offered; and
* Practice his own religion; and
* Wear his own clothing and to retain and use personal possessions; and
* Be informed of his medical and habilitative condition, of services available at the agency and the charges for the services; and
* Reasonable access to all records concerning himself; and
* Refuse services; and
* Exercise all civil rights, unless limited by a prior court order.

1. **Additional Participant Rights. The agency must also ensure the following rights:**

* Privacy and confidentiality; and
* Be treated in a courteous manner; and
* Receive a response from the agency to any request made within a reasonable time frame;
* Receive services which enhance the participant’s social image and personal competencies and, whenever possible, promote inclusion in the community; and
* Refuse to perform services for the agency. IF the participant is hired to perform services for the agency the wage paid must be consistent with stat and federal law; and
* Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; and
* All other rights established by law; and
* Be protected from harm.

**Participant Responsibilities**

1. In addition to the rights listed above, every Member has the responsibility to:

* Supply information (to the extent possible), that Optum and its network practitioners need in order to provide care
* Follow plans and instructions for care that they have agreed on with his or her network practitioner • Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible
* Keep scheduled appointments and actively participate in treatment

I have had these rights and responsibilities explained to me by a NBCSS staff member. In addition to a copy of this form, I have received a packet of information that outlines access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. It has also been explained to me.

Clients Name

Client/Guardian Signature Date

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Witness Signature Date

Procedure:

Participant and guardian are informed of participant rights verbally by worker. Participant and guardian are to be provided with a packet of information which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet will be written in easily understandable terms and be given upon the initiation of services. Participant rights are posted in the center near the restrooms.

If you have a complaint, grievance, or in any way feel that your rights have been violated we encourage you to contact our Directors, Stephanie Beidman and Elaine Dufford, and make a formal written complaint using the attached *Participant/Guardian Grievance Form*.

Their contact information:

Stephanie Beidman, LMSW

800 Main Street #11

Lewiston, ID 83501

P (208) 746-7661

F (208) 746-0811

Our Director will review your grievance and contact you via phone or in person regarding it within two (2) working days in order to assist in remedying the situation.

If you feel that your grievance can not be/is not satisfied in the above manner, please contact:

|  |  |  |
| --- | --- | --- |
| **OPTUM Idaho**  205 East Water Tower Lane Meridian, ID 83642  Phone:  (855) 202-0973 | **Idaho State Health and Welfare, Lewiston**  2604 16th Ave. Lewiston, ID 83501  (208) 799 – 3460  (208) 799 - 4440 | If you are being abuse or suspect that your child is being abused: Child Abuse And Neglect Reporting/24 Hour  Idaho State Health and Welfare, Lewiston  Bldg 1118 F Lewiston, ID 83501  (208) 799 – 4360 |

**Participant/Guardian Grievance Form**

Please fill out and turn this form into NBCSS Director, Stephanie Beidman.

Name of person completing report (please print):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am (circle one):

(A) Participant (B) Guardian, my son or daughter’s name is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grievance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What I would like to see done about it:

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Clients Name

Client/Guardian Signature Date

Witness Signature Date

**Participant/Guardian Grievance Form Cont…**

Director’s Response:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was participant/guardian(s) contacted via phone or in person within two (2) working days of receiving this report?

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YES \_\_\_\_ NO \_\_\_\_

If no, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was grievance addressed and remedied?

YES \_\_\_\_ NO \_\_\_\_

If no, explain steps to be taken to do so:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Clients Name

Client/Guardian Signature Date

Witness Signature Date

Rights Form

A representative of New Beginnings Counseling and Support Services has explained the following to me in detail:

\_\_\_\_\_\_ I may refuse or terminate services at any time during the course of treatment.

\_\_\_\_\_\_ I have the right to be treated respectfully and to have my questions/concerns addressed in a timely manner.

\_\_\_\_\_\_ I have the right to receive services at the times that are convenient for me/my family.

\_\_\_\_\_\_ I was made aware there are other agencies that provide similar services and was offered a list of these agencies.

\_\_\_\_\_\_ I have the right to appeal the decision of SRCS. If I have questions, I can contact the Optum Client’s Representative @ 855-202-0973. I can also call this number in the event of a grievance with the agency.

YOUR COPY TO KEEP

\_\_\_\_\_\_ I have been given the phone numbers and address of both local and state authorities in the event of an appeal or to raise concerns regarding my treatment or that of a child in my care.

\_\_\_\_\_\_ I have been made aware that I have the right to legal services, support in the event I have a grievance.

\_\_\_\_\_\_ I understand I can access emergency services in the event of a crisis by contacting the SRCS office at 208-746-7661 between the hours of 9:00am-5:00pm, or by calling the providers cell phone that will be provided to each client after hours for 24/7 coverage.

I have received and reviewed the following documents:

\_\_\_\_\_\_ The Participant Rights Form

\_\_\_\_\_\_ The Client Grievance Policy

By signing below, I acknowledge the above indicated issues have been explained in full and that I wish to select New Beginnings Counseling and Support Services as my treatment provider.

Clients Name

Client/Guardian Signature Date

Witness Signature Date

|  |  |  |
| --- | --- | --- |
| A to Z Family Services | 1275 Riverside Ave, Orofino, ID 83544 | 208.476.7483 |
| Adult Mental Health Services | 1118 F Street, Lewiston, ID 83501 | 208.799.4440 |
| Anderson, Gallaher & Associates Counseling | 450 Thain Road Suite F, Lewiston, ID 83501 | 208.743.0150 |
| Bridgeway Counseling Center | 324 5th Street, Lewiston, ID 83501 | 208.746.7667 |
| Camas Professional Counseling | 304 N State Street, Grangeville, ID 83530 | 208-983-0235 |
| ChangePoint Behavioral Health | 1020 Main Street, Lewiston, ID 83501 | 208.750.1000 |
| Child and Family Enrichment Center | 619 S Washington Street #301, Moscow, ID 83843 | 208.882.9200 |
| Clearwater Counseling | 1014 Main Street, Lewiston, ID 83501 | 208.743.8301 |
| Harmony Counseling Center | 309 2nd Street, Lewiston, ID 83501 | 208.746.0137 |
| Kevin Kracke & Associates | 422 17th Street, Lewiston, ID 83501 | 208.743.4680 |
| New Beginnings Counseling & Support Services  YOUR COPY TO KEEP | 800 Main Street #11; Lewiston, ID 83501 | 208.746.7661 |
| Nimiipuu Health | 111 Bever Grade, Lapwaii, ID 83540 | 208.843.2271 |
| Opportunities Unlimited | 325 Snake River Ave, Lewiston, ID 83501 | 208.743.1563 |
| Phillips Agency Inc. | 532 Bryden Ave, Lewiston, ID 83501 | 208.746.8288 |
| Quality Behavioral Health | 900 7th Street, Clarkston, WA 99403 | 509.758.3341 |
| RiverPlace Counseling & Wellness | 312 Miller Street, Lewiston, ID 83501 | 208.750.1802 |
| Riverside Recovery | 1720 18th Ave, Lewiston, ID 83501 | 208.746.4097 |
| Scott Community Care | 317 W 6th Street #208, Moscow, ID 83843 | 208.882.3504 |
| Sequoia Counseling Services | 531 Bryden Ave, Lewiston, ID 83501 | 208.798.1646 |
| Weeks and Vietri Counseling | 818 S Washington Street, Moscow, ID 83843 | 208-882-8514 |

**Provider List**