



JETTMORGAN

TREATMENT SERVICES, LLC
Neuroscience of Change

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

General Information:

Information regarding your health care, including payment for health care is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d et seq., 45 CFR Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 CFR Part 2. Under these laws, Jett Morgan Treatment Services LLC may not say to a person outside Jett Morgan Treatment Services LLC that you attend the program, nor may Jett Morgan Treatment Services LLC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Jett Morgan Treatment Services LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Jett Morgan Treatment Services LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Jett Morgan Treatment Services LLC can share information for treatment purposes or for health care operations. However, federal law permits Jett Morgan Treatment Services LLC to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/business associate;
2. For research, audit, or evaluations;
3. To report a crime committed on Jett Morgan Treatment Services LLC premises or against Jett Morgan Treatment Services LLC personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report suspected child abuse or neglect;
6. As allowed by a court order.

For example, Jett Morgan Treatment Services LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before Jett Morgan Treatment Services LLC can use or disclose any information about your health in a manner, which is not described above, we must first obtain your specific written consent allowing the disclosure. Any such written consent may be revoked by you in writing.

Your Rights

Under HIPAA, you have the right to request restrictions on certain uses and disclosures of your health information. Jett Morgan Treatment Services LLC is not required to agree to any restrictions you request, but if we do agree then Jett Morgan Treatment Services LLC is bound by that agreement and may not use or disclose any information, which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Jett Morgan Treatment Services LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA, you also have the right to inspect and copy your own health information maintained by Jett Morgan Treatment Services LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in the other limited circumstances.

Under HIPAA, you also have the right, with some exceptions, to amend health care information maintained in Jett Morgan Treatment Services LLC's records, and to request and receive an accounting of disclosures of your health related information made by Jett Morgan Treatment Services LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Jett Morgan Treatment Services LLC's Duties

Jett Morgan Treatment Services LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Jett Morgan Treatment Services LLC is required by law to abide by the terms of this notice. Jett Morgan Treatment Services LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains.

Complaints and Reporting Violations

You may complain to Jett Morgan Treatment Services LLC and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Contact

For further information, contact Jett Morgan Treatment Services LLC Clinical Director, Jim Morgan at 907-677-7709

Effective Date: 3/28/2011

Acknowledgement:

I hereby acknowledge that I have received a copy of the Health Insurance Portability and Accountability Act of 1996. (Also known as "HIPAA")

Printed Name

Date

Signature



700 W. 6th Avenue, Suite 208
Anchorage, AK 99501
907-677-7709 Phone
907-677-7095 Fax

Informed Consent for Screening, Assessment and Referral

I, _____, DOB, _____, hereby acknowledge that I consent (agree to) receiving a screening and/or assessment for alcohol and drug abuse issues and treatment referral services from Jett Morgan Treatment Services, LLC.

SECTION I: GENERAL

- ___ I agree to actively participate in the screening, assessment and referral processes. I understand that it is my responsibility to follow up with all recommendations and referrals.
- ___ I understand that my consent for alcohol and other drug treatment services is voluntary and may be withdrawn at any time.
- ___ I further understand that any changes in my assessment and/or treatment recommendations will be discussed with me prior to such changes becoming effective.
- ___ Subject to ongoing assessment and evaluation of my treatment progress, I may expect changes in the level and duration of services while I am enrolled. Further, I may expect these changes to be discussed by the treatment team and any modifications will be in the best interest of my treatment.
- ___ I acknowledge and understand that no promise or guarantees have been made to me regardless of the outcome of my treatment referral by Jett Morgan Treatment Services, LLC and do hereby absolve Jett Morgan Treatment Services, LLC from liability in the event my treatment referral is unsuccessful.
- ___ I hereby authorize Jett Morgan Treatment Services, LLC to contact me by mail, telephone, email or in person after my screening, assessment, or referral as follow-up is an integral part of my overall treatment.

SECTION II: ATTENDANCE & TREATMENT CHARGES

- ___ I agree to be on time for all scheduled appointments. I understand that if I am late, I may be rescheduled or returned to my referral source.
- ___ I agree to contact the agency 24 hours prior to missing a scheduled appointment to reschedule. I understand that if I fail to provide 24-hour notice to cancel or reschedule my appointment I will be charged a late cancellation fee.
- ___ I acknowledge that all fees for services are due to and payable at the time of the service unless other arrangements have been made for me.

SECTION III: EXPLANATION OF RIGHTS

1. Rights of Confidentiality

Client records maintained by Jett Morgan Treatment Services, LLC are considered confidential and will not be released to other individuals or agencies without your express written consent. However, certain information may be released without your authorization under the following circumstances:

- Upon receipt of a legitimate court order
- In the event of a valid medical emergency
- If there is evidence to suggest that child abuse has occurred
- Authorized research or audit purposes
- A crime or threat of a crime
- Internal communication purposes

Note: A summary of the confidentiality law/regulation is given to each client.

2. Bill of Rights

A consumer is entitled to participate in formulating, evaluating and periodically reviewing his/her individualized written treatment plan, including requesting specific forms of treatment, being informed why requested forms of treatment are not made available, refusing specific forms of treatment that are offered, including his/her preferences in the treatment process, and being informed of treatment prognosis.

A consumer has the right to review with a staff member, at a reasonable time, his or her treatment record. However, information confidential to other individuals may not be reviewed. A consumer will be informed by the prescribing physician of the name, purpose, and possible side effects of medication prescribed as part of their treatment at Jett Morgan Treatment Services, LLC. A consumer may request a copy of the assessment summary that should include referrals and follow-up plans.

3. Civil Rights

The Civil Rights Law of 1964 requires that community service agencies notify consumers that services and benefits are provided without distinction as to race, color, or national origin.

If you believe that discrimination on account of race, color, or national origin is being practiced against you, you have the right and are encouraged to file a written complaint with the Director of the program providing the services or benefit, and with the Department of Civil Rights, Department of Health, Education and Welfare, Region X 1231 Second Avenue, Seattle, Washington 98101. Complaints will be promptly investigated and a fair hearing arranged.

SECTION IV: CONFIDENTIALITY AND ANONYMITY AGREEMENT

It is essential that all persons visiting, attending, incarcerated and or residing at Jett Morgan Treatment Services, LLC understand the importance of safeguarding the confidentiality and anonymity of those individuals who are seen on these premises or who are receiving any type of service.

Federal regulations prohibit anyone from making any type of disclosure without the specific written consent of the person to whom it pertains. Therefore, the undersigned person certifies his or her agreement not to divulge, publish or otherwise make known to any unauthorized third party, orally or in writing, any information obtained from or on behalf of a client of Jett Morgan Treatment Services, LLC.

The undersigned further understands that any unauthorized disclosure of client information or records can subject him or her to a civil action for damages or a fine of \$1,000 or three times the amount of actual damages sustained by a willful release of confidential information under government regulations, or criminal prosecution, both State and Federal, in an amount of not more than \$500 in the case of a first offense and not more than \$5,500 in the case of each subsequent offense.

Those at least twelve (12) years of age and above must sign this form. Persons accompanying children under the age of twelve years must explain to them the importance of respecting the complete privacy of those at Jett Morgan Treatment Services, LLC as well as the events or activities occurring therein.

Client Statement:

My signature below indicates that I have read, have had the opportunity to discuss and ask questions about the foregoing "Treatment Authorization", and received a copy of this informed consent form; that I fully understand the meaning of each point; that I knowingly and voluntarily consent to the terms of each one; and that I have not been under any duress or force nor under the influence of alcohol or other drugs.

Signature of Client

Date

Witness Statement

My signature below indicates that I have witnessed and now certify the validity and legitimacy of the above client's signature

Signature of Witness:

Date:



EMERGENCY CONTACT INFORMATION

Client Name: _____ Client Number: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Mess Phone: _____

Allergies: _____

Medical Conditions: _____

Medications: _____

Medical Provider Name/Phone: _____

Preferred Hospital: _____

Primary Emergency Contact

First & Last Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Mess Phone: _____

Secondary Emergency Contact

First & Last Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Mess Phone: _____

I authorize Jett Morgan Treatment Services, LLC to provide the information contained on this form to emergency medical providers in case of a medical emergency.

Client Signature _____ Date _____



Date: _____

Last Name:		First Name:		Middle:
Please list any previous legal names:		Social Security Number:		
Birthdate:	Age:	Sex:	Marital Status (check one)	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Cell Phone Number:	May we leave voice message?		May we leave text message?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Phone Number:		May we leave voice message?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Work Phone Number:		May we leave voice message?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Facebook Address:		May we contact via private message?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address:		May we contact you at email address?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Street Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Employer Name:		Have you served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Active: <input type="checkbox"/> Yes <input type="checkbox"/> No Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No Branch: _____ Combat: <input type="checkbox"/> Yes <input type="checkbox"/> No Era: Vietnam Gulf Iraq Afghan Other Type of discharge: _____ Military Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Presenting Problem/What led to you coming here?

Date: _____

Referred By: <i>Check ALL that apply</i>		
<input type="checkbox"/> Attorney <input type="checkbox"/> Cook Inlet Tribal Center <input type="checkbox"/> Court-ASAP <input type="checkbox"/> Court-Civil proceedings <input type="checkbox"/> Court-Mental health <input type="checkbox"/> Court-OWL <input type="checkbox"/> Covenant House <input type="checkbox"/> Employee Assistance Program <input type="checkbox"/> Employer <input type="checkbox"/> Family/friend	<input type="checkbox"/> Halfway House <input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Medical provider <input type="checkbox"/> Mental health-outpatient <input type="checkbox"/> Mental health-inpatient <input type="checkbox"/> Office of Children Services <input type="checkbox"/> Probation/Parole (Federal) <input type="checkbox"/> Probation/Parole (State) <input type="checkbox"/> Self	<input type="checkbox"/> School <input type="checkbox"/> South Central Foundation <input type="checkbox"/> Substance abuse-detox <input type="checkbox"/> Substance abuse-outpatient <input type="checkbox"/> Substance abuse-residential <input type="checkbox"/> Transitional housing <input type="checkbox"/> Village Health Aide <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Other: _____
Race and Ethnicity: <i>Check ALL that apply</i>		
<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian: _____ <input type="checkbox"/> Other: _____ Alaskan Native: <input type="checkbox"/> Aleut <input type="checkbox"/> Athabascan <input type="checkbox"/> Haida <input type="checkbox"/> Inupiat <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> Other: _____	Hispanic or Latino: <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South American: _____ <input type="checkbox"/> Central American: _____ <input type="checkbox"/> Other: _____ <div style="border: 2px solid black; padding: 5px;"> <p>Citizenship: _____</p> <p>Place of Birth: _____</p> <p>Religious Preference: _____</p> <p>Sexual Orientation: _____</p> </div>	
Special Needs: <i>Check ALL that apply</i>		Service Preferences: <i>Check ALL that apply</i>
<input type="checkbox"/> None <input type="checkbox"/> Developmentally disabled <input type="checkbox"/> Major difficulty in moving <input type="checkbox"/> Moderate/severe medical problems <input type="checkbox"/> FAS/FAE/FASD <input type="checkbox"/> Severe hearing loss or deaf <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Visual impairment or blind <input type="checkbox"/> Other: _____ Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you require special assistance while attending treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Access to Recovery (ATR) <input type="checkbox"/> Alcohol Drug Information School (ADIS) <input type="checkbox"/> Aftercare <input type="checkbox"/> Assessment <input type="checkbox"/> Family Involvement <input type="checkbox"/> Mental health referral <input type="checkbox"/> Recovery Support Services (RSS) <input type="checkbox"/> Treatment--Outpatient <input type="checkbox"/> Treatment--Intensive Outpatient <input type="checkbox"/> Treatment--Residential <input type="checkbox"/> Other: _____
Education:		Language:
<input type="checkbox"/> If K-11, how many years? _____ <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> Vocational training <input type="checkbox"/> Post-Secondary (no degree) <input type="checkbox"/> AA degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral degree Were you enrolled in Special Ed or had an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is English your first language? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what is your first language? _____ How would you rate your ability to understand English? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Not at all Will you require help understanding English? <input type="checkbox"/> Yes <input type="checkbox"/> No How would you rate your ability to write in English? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Not at all Will you require help writing English? <input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Use Information:		
Substance of Choice:		Ever IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No



Late Cancellation Policy

- All scheduled appointments are subject to a no show/ late cancellation fee of **\$25.00** if you fail to cancel or reschedule your appointment 24 hours prior to the scheduled appointment.
- You are required to pay late cancellation fees at your next appointment. All fees are expected at the time services are rendered and you will not be seen or admitted into group until payment is received.

My signature signifies that I have read and understood the above.

CLIENT SIGNATURE

PRINT NAME

DATE

STAFF SIGNATURE

DATE



REFUND POLICY

- ◆ Jett Morgan Treatment Services, LLC does not provide refunds for any monies paid, **NO EXCEPTIONS**.
- ◆ This includes pre-paid assessments and sessions. It is ***your*** responsibility to follow through with all appointments.
- ◆ If you have any questions or concerns, please contact Michelle Jett or Jim Morgan, at 907-677-7709.

My signature below signifies that I have read and understood Jett Morgan Treatment Services, LLC refund policy.

Client Signature

Date

Staff Signature

Date