Welcome to Cognitive Restructuring!

We are happy you chose us to be your Service Provider!

Please fill out the following questions and let the staff know if you have any questions.

Your clinician will be with you shortly.

Thanks very much!

Cognitive Restructuring LLC
707 North 7th Ave, Ste #D
Pocatello, Idaho 83201
208-242-3044 (Phone)
208-904-0494 (Fax)

 Revised 10/26/2021

Client Support Sheet

Client Name:______________________ Phone: ( ) ____-________ Email: ______________________

Address: ______________________ City: ______________ State: ______________ Zip: ______________

Date of Birth:_____/_____/_____Social Security Number: ____-____-____ Age:_____ Gender:______________

Date Completed: ______________________ Employer/School: ______________________

Emergency Contact Name:______________________ Phone: ( ) ____-____ Relationship: ______________

Emergency Contact Name: ______________________ Phone: ( ) ____-____ Relationship: ______________

Legal Guardian/POA Name (If applicable): ______________________ Phone: ( ) ____-________

Outside Agency Contacts:		Phone	Email	**ROI:**	Refused	None
Counselor/Therapist:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Case Manager:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Peer Support Specialist:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Psychiatrist/Psychologist:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Primary Care Physician:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Probation Officer:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Family Member:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Other Medical Provider:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐
Other:	________	Phone: (___)____-____	Email: ________	Y N Date: Faxed: ________	☐	☐

Primary Insurance Company______________________ **Member ID #** ______________ **Group#**__________

Insurance Company______________________ **Member ID #** ______________ **Group#**__________

Reason(s) for starting Services:____

Comments:____

____

Revised 10/26/2021

Cognitive Restructuring, LLC

Protections under HIPAA and Omnibus Rule 9-23-2013

Name: ____ Date: ____________________

Information Line: 1-800-368-1019

Access to Medical Records

Clients may have access to medical records to copy and amend or request amendments
Access will be provided within 30 days of client request for their file review
Is permissible to charge client for copying and sending costs

Request an Accounting of Record

Client may request a listing of records of individuals that personal information was shared with

Privacy

Clients signs or initial or otherwise acknowledges written document of how their health information is to be used
If client does not agree they can disagree to any of the reasons

Limit Use of Medical Information

Even when disclosure is given by client, release minimal information to meet the purpose

Prohibition on Marketing

Can use client success for marketing with client permission of specific authorization of what will be disclosed

State Law Strength

Reporting based on state law does not violate HIPAA regulations

Confidential Communication

Client can request to ONLY be called at work and must be reasonably accommodated

File Complaints

On-line at http://www.hhs.gov/ocr/hipaa or by calling (866) 627-7748
Complaints can be filed with provider or with Office for Civil Rights, above

Training

Entities must train personnel in privacy and designate a person responsible to ensure procedures are followed
Disciplinary action by the entity must be taken when personnel fails to follow procedures

Public Responsibilities

Entities may continue to disclose for public responsibility based on judgment and entity policy
Identification of a body of a deceased person
Cause of death
Communicable disease reporting or to avert serious threat to health or safety
Limited data or has been approved by Institutional Review Board or privacy board
Oversight of health care system
Judicial and administrative proceedings
When required by military; command authorities if client in military
For persons in police custody to protect safety and security of correctional institution
Limited law enforcement activities
Workman's Compensation information needed to complete claim process
To business associates within the entity structure

- Injury or disability
- Abuse or neglect
- Provide information about a crime
- Activities related to national security
- To locate or apprehend a suspect, fugitive, or missing person
- Report a crime on the premises and if entity is responding to an emergency report crime information

Equivalent Requirement for Government

Rules apply to private and public entities

OMNIBUS Rule updates: Clients may opt out of fundraising, can limit disclosure to insurance company if pay in cash, has the right to be notified of breach of health record information, to not have health information sold or marketed, to have health records safely stored, to be able to view Notice of Privacy Policies, and to have hard copy and digital records safeguarded within HIPAA compliance.

______________________________________ ______________________

Client/Parent/Guardian Signature Date

Provider Choice List

Cognitive Restructuring, LLC

(Circle choice of provider)

Mental Health	Drug and Alcohol
Cognitive Restructuring, LLC A New Way Inc., AAA American Healthcare LLC, Access Point Family Services Inc., Adult and Child Development Center, Allies Family Solutions, Bannock Youth Foundation, Behavioral Treatment Center, Benjamin Douglas, Bright Tomorrows, Candlewood Family Counseling Center Inc, Cassia Morton, Center Counseling Services, Community Mental Health Services, Community Wellness Center Inc., Consumer Care LLC, Crete Brown, Gateway Counseling Inc., Health West Inc., Healthy Place Counseling Pocatello, Hope Tree Inc., Jodyne Bilstrom, Joshua D. Smith and Associates, Life Change Associates, Mental Health Specialists, High Country Behavioral Health, Natasha Cutler, New Horizons Mental Wellness Clinic, Pacific Rim Consulting LLC, Physicians Mental Health Services, Pocatello health Services LLC, Portneuf Valley Family Center, Psychological Assessment Specialists, Shoshone Bannock Clinic, Stacy Pray, T Help LLC	Cognitive Restructuring, LLC A New Way Inc. Bannock Youth Foundation- MK Place Consumer Care LLC Gateway Counseling Inc. Joshua D. Smith & Associates Pacific Rim Consulting LLC Portneuf Valley Family Center Inc.

I understand there are many providers in the area, and I am free to choose my provider. I also understand that I may change providers at any time.

________________________________ ________________

Client/Guardian Signature

Cognitive Restructuring, LLC

Client Rights and Responsibilities

- You have the right to be treated fairly, with dignity, and with respect for your right to privacy. This includes refusing to be recorded, videotaped, or photographed.
  - To refuse to be part of research study without permission
- You have the right to receive all health care services in a caring, non-judgmental way.
- If you have a disability you have the right to receive information in a style that meets your needs.
- The term "Client" may, as appropriate, include family members (release of information exchange required for adult clients), a court-ordered legal guardian, or designated representative in an activated advance directive.
- You have the right to get health care services in a way that respects your culture, race, color, age, disability, religion, gender, gender identity, sexual orientation, physical characteristics, or veteran status.
- This includes getting you an interpreter if you do not speak English.
- You have the right to take part in all health care decisions. This includes treatment and recovery planning. You also have the right to refuse treatment.
- You have the right to have and take medications prescribed by a physician.
- You have the right to understand any treatment you agree to receive. This is called informed consent.
- You have the right to choose someone to help with care choices.
- You have the right to get a second opinion from a provider at no cost. You can get a second opinion when you:
  - Need more information about a treatment.
  - Think the agency or care provider is not providing the right care.
- You have the right to make a complaint about the care you are receiving. This is a way to take charge of your recovery. Complaints can be made about the agency, a care provider contracted with the agency, or anything else about your treatment experience.
- You have the right to choose your care providers from the agency.
- You have the right to have a psychiatric advance directive (PAD). A PAD is a legal document you can use to manage your mental health treatment and wellness if you cannot make or communicate decisions about your treatment. A PAD can say which people you do or do not want to make choices for you.
- You have the right to see your own behavioral health treatment records. This is based on federal and Idaho laws and rules. You have the right to restrict who sees those records based on those laws and rules. You have a right to make amendments to records to correct errors or inaccuracies.
- You have the right to ask for and get information about the agency. This includes its services and how to access them.
- You have the right not to be bothered by either side if problems come up between the agency and its personnel.
- You have the right to not be restrained or secluded based on federal or state rules on the use of restraints and seclusion.

Client Responsibilities are on the next page.

Cognitive Restructuring, LLC

Client Rights and Responsibilities

- The agency asks that every Client is aware of the following responsibilities:
- You are responsible for providing the agency and the care providers with information needed to provide quality care.
- You are responsible for understanding your health problems to the best of your ability. You are responsible for participating in treatment and recovery goals both you and your care providers agree on.
- You are responsible for following these treatment and recovery plans to the best of your ability. You must let providers know if changes are needed.
- You are responsible for keeping, changing, or cancelling appointments instead of not showing up.

__________________________________ __________________

Client/Parent/Guardian Signature Date

Cognitive Restructuring, LLC

Information Disclosure and Consent

Date: ______________________

Client Name: ______________________

Parent Guardian Name: ______________________

Confidentiality: The confidentiality of all client records maintained by this program is protected by Federal Law and Regulations. Violation of the Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Generally, the program may not say to any person outside the agency that a patient attends a program or services, or disclose any information identifying a client. Information may only be disclosed under the following circumstance(s):

1) The Patient consents in writing;
2) The disclosure is allowed by a court order or subpoena; or
3) The disclosure is made to medical personnel for research, audit or program evaluation.

Client Information disclosed to a licensed counselor is a privileged communication and cannot be disclosed in any or criminal court proceedings in Idaho without the consent of the client. However, under the Idaho Rule of Evidence 517(d) there is no privilege for the following acts:

Civil Action: In a civil action case or proceeding by one of the parties to the confidential communication against each other.

Proceedings for Guardianship, Conservatorship, and Hospitalization: As a communication relevant to an issue in proceedings for the appointment of a guardian conservator for a client for mental illness or to hospitalize the client for mental illness.

Child Related Communications: In a criminal or civil action or proceeding as to a communication relevant to an issue concerning a physical, mental, or emotional condition of or injury to a child, or concerning the welfare of a child including, but not limited to abuse, abandonment or neglect of a child. Federal Law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Licensing Board Proceedings: In the action, case, or proceeding under Idaho Code 54-3403. Individual licensure laws may require the release of confidential information in the event that there is imminent danger of harm to self or others.

Contemplation of a Crime or Other Harmful Act: If the communication reveals the contemplation of a crime or intention to commit a harmful act.

Insurance, Medicaid, and Other Payment Companies: Information needed for billing purposes.

Prohibition of Re-Disclosure Statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by rules (42 C.F.R. Part 2.) A general authorization for the release of medical or other information is not sufficient for this purpose. The federal

rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse of patient. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal Regulations).

When Information May be Shared Without Your Permission: For public health risks, as required by law, emergency treatment, or to prevent a serious threat to health and safety of others.

Release of Information: Information pertinent to care and treatment may be released to insurance companies, other entities for reimbursement purpose, as well as others indicated on signed releases, to be updated at least annually. In regard to individuals court ordered to treatment or have probation officers: Information may be required to report such as substance use, attendance, or rule violations.

HIPAA Notice of Privacy: We are dedicated to protecting your confidential information. We create records of the services provided and forwarded copies of records provided by other service providers. We are required to use and disclose confidential information as required by law, maintain the privacy of your information, give you this notice of our legal duties and privacy practices for your information, and to follow the terms on the current HIPAA guidelines that are currently in effect.

HIPAA Regulations: I understand my rights regarding my private health information and have been provided a copy of the HIPAA laws and have been provided with contact numbers should I have a complaint regarding the use of my child's or my health information.

Right to Review and Copy: You have the right to review and copy your clinical information as allowed by law. You may request any documentation completed by Cognitive Restructuring, LLC Information provided by another agency or entity will need to be requested from that agency or entity.

Right to Amend: You have the right to ask to make changes to your information if you feel the information, we have is incorrect or incomplete. A Request of Amend Records form is available for your use. You must complete the form and return it to the front office for processing. Our office will respond to your request within 10 days. We may deny your request if you ask us to change information when the document was not created in our office, when the information is derived from a court document, when the data is historical in nature and is from the perspective of a biological family member or a member within the family, when we determine the information in court ordered mental health assessment completed by a clinician is an objective cultural representation of the clients current mental health information and/or diagnosis currently at this time.

Emergency or Crisis Plan: Please call our number anytime. Our answering machine will give you the 24 hour on-call number; which you may call in the case of an emergency. In the event of no response, call 911 or go to your local hospital.

Complaints: If you believe your privacy rights have been violated, you may file a written complaint with our office. All complaints turned into our office must be in writing.

Right to Refuse: Treatment may be refused, or consent revoked at any time, if desired by the client. There are many providers from which to choose. Cognitive Restructuring, LLC is only one of those providers.

Length of Treatment: Will depend upon types of issues and concerns present as well as motivation for goal attainment. Average length of time in treatment is between six months and one year.

Infractions: In the event that an entire week is missed of treatment, this will be documented in your file and as probation and parole officers are contacted weekly, a report of no attendance for that week will be given. In the event, that two weeks of no attendance, discontinuation of services may result.

Special Commitments and Instructions for Groups:
Client agrees and commits to attend groups as collaboratively agreed upon.
Client agrees to attend all groups and individual sessions sober.
Client agrees to notify Cognitive Restructuring, LLC and other overseeing professionals if groups are missed.
Client agrees to laws of confidentiality and failure to abide by confidentiality regulations will constitute dismissal from group.

Cognitive Restructuring, LLC

Information Disclosure and Consent

Documentation: Documentation is maintained regarding the services received. You have the right to access your records. These records are confidential and cannot be released without client consent, a court order, or during a state or federal audit.

Professional Standards: Professionals adhere to the National Association of Social Workers Code of Ethics. The Bureau of Occupational Licensing regulates the practice of professionals. The licensure of an individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of treatment.

Second Opinion: Any time in treatment, client may seek a second opinion. This is the responsibility of the client to choose the provider. The client may terminate services at any time unless treatment is court ordered.

Risks: Treatment is not guaranteed to cause positive results. Risk of treatment may include a worsening of behaviors or conditions preceding potential improvement. Lack of treatment or discontinuation of treatment may also lead to worsening of behaviors or conditions that may deter potential improvement.

Alternatives: There are alternative or additional treatments that may be beneficial such as individual counseling, medication management, religious and cultural services.

Emergency Medical Care: I give Cognitive Restructuring, LLC who is the representatives of the above-named individual, consent for any and all necessary emergency medical care for me or my child when client is within the agency's care. I give permission to share with medical personnel necessary information to protect me or my child immediate emergency health risks.

Fees: Portions of rendered services may be covered by insurance, Medicaid, or others. If you do not have insurance coverage or services are not covered by your insurance company, fees may be paid for privately at the following fee schedule:

Selection of Service Choice "x"	**Services Offered:**	**Description and Goal of Service:**
	Anger Management	6 sessions, helping the individual in learning techniques of emotional regulation.
	Case Management	Assisting Drug and Alcohol clients to access appropriate services and maintain sobriety.
	Drug and Alcohol Outpatient or Intensive Outpatient Treatment	Helping individuals work toward sobriety and high functionality in all 6 dimensions of treatment and to enhance quality of life. Hours: 8 am to 8 pm.
	Drug Testing	On-site drug testing for individuals involved in Drug and Alcohol Treatment.
	DUI Assessment and Education	12-hour education using MRT Driving the Right Way, CBT, Motivational Interviewing, and safety planning
	Parenting Support	Helping care givers in learning techniques of attachment and interactions
	Community Based Rehabilitation Services	Individual behavioral skills training and community reintegration designed to help the individual gain the optimal level of independent functioning.
	Individual Psychotherapy	Helping the individual in their search for understanding and resolution.
	Peer Support Services	Individual skills recovery-focused approach promoting the development of wellness self-management, personal recovery, natural supports, coping skills, and self-advocacy skills.

Information Disclosure and Consent

Selection of Service Choice "x"	Other Choice of Services:	Description and Goal of Service:	Payment Schedule
	Cognitive Self Change	Stage 1 and/or 2 Idaho Model	$25 per group
	MRT	12 Step interactive program with homework	$50 per group
	Drug and Alcohol Education Only	2-12 hours education	$25 per group $50 for ½ hour individual
	Other:		

Service	Payment Schedule *(costs are subject to change)*
All Services if Private Pay/Self Pay are to be paid by Money Order or Cash in advance	
Anger Management	$160.00 for 8 sessions
Comprehensive Diagnostic Assessment	$180.00
Community Based Rehabilitation Services	$45.00 per hour or Medicaid funded program
Drug and Alcohol Outpatient or Intensive Outpatient Treatment	$25.00 per group $50.00 for an individual session ½ hour. $100.00 for an individual session 1 hour. *Reduced rates may be available for individuals upon consultation with billing department.*
Drug Testing	$15.00 per test
DUI Assessment	NOT AVAILABLE – REFER OUT
Gain Assessment	$180.00
Mental Health Intake	$110.00 for Intake if private or self-pay
Individual Psychotherapy	$55.00 for an individual session ½ hour. $110.00 for an individual session 1 hour. *Reduced rates may be available for individuals upon consultation with billing department.*
Parenting	$160.00 for four-week class

Cognitive Restructuring, LLC

Information Disclosure and Consent

Please indicate the following statements that pertain to you:

	I do not have insurance coverage and I agree to pay the fees for services I receive.
	I have insurance coverage. I give Cognitive Restructuring, LLC Permission to bill my insurance for services I am receiving. I agree to pay the balance of my account that is not covered by my insurance.
	I agree to pay the amount of my **co-pay** at the time of services.

I understand that I may receive services from a Trainee under supervision. I consent to being treated by a Trainee and understand that I may request a QP for my treatment.

I understand my rights and have asked any questions regarding the above information. I willingly agree with the content of this document and consent to treatment through Cognitive Restructuring, LLC with the understanding of the previously stated disclosures.

Client/Guardian Signature　　　　　　　　　　Date

Personnel Signature　　　　　　　　　　Date

Cognitive Restructuring, LLC

Client Email/Texting Informed Consent Form

1. **Risk of using email/texting**

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.

c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

d. Employers and on-line services have a right to inspect emails sent through their company systems.

e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

f. Email and texts can be used as evidence in court.

g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of email and texts**

Cognitive Restructuring, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Cognitive Restructuring, LLC is not liable for improper disclosure of confidential information that is not caused by Cognitive Restructuring, LLC intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.

d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.

e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.

f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between Cognitive Restructuring, LLC and me, and the conditions and instructions outlined, as well as any other instructions that my Provide or Therapist may impose to communicate with me by email or text.

Please mark only 1 choice below by initialing:

_____ I **wish** to be contacted by email at the following email address:

Email: ____

_____ I **wish** to be contacted by text at the following phone number:

Phone: ____

_____ I **do not wish** to be contacted by email or text by Cognitive Restructuring, LLC

Client Name: ____

Client Signature: ______________________________ Date: ________________

Parent/Legal Guardian Name: ______________________

Parent/Legal Guardian Signature: ___________________ Date: ________________

Cognitive Restructuring, LLC

Employee Signature: ____________________________ Date: ________________

Cognitive Restructuring, LLC

TeleHealth Informed Consent Form

1. **Risk of using electronic devices for services:**

The transmission of member information by electronic device or telephone has a number of risks that members should consider prior to the use of electronic device or telephone. These include, but are not limited to, the following risks:

a. Information can be circulated, forwarded, stored electronically and broadcast to unintended recipients.

b. Senders can easily misdial or send the information to an undesired recipient.

c. Electronic devices may create backup information even after the sender and/or the recipient has deleted his or her copy.

d. Electronic devices may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of electronic media for sessions:**

Cognitive Restructuring, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of all sessions done by any staff member. Cognitive Restructuring, LLC is not liable for improper disclosure of confidential information that is not caused by Cognitive Restructuring, LLC intentional misconduct. Members/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Electronic media may not be appropriate for urgent or emergency situations. Cognitive Restructuring Provider cannot guarantee that any particular email and/or telephone voice mail will be read and responded to within any particular period of time.
b. Cognitive Restructuring will make every effort to provide services to a member at a prior designated and scheduled time unless the member requests an immediate session.
c. A note of the session will be placed in the member record.
d. Provider will not forward member's/parent's/legal guardian's identifiable emails and/or texts without the member's/parent's/legal guardian's written consent, except as authorized by law.
e. Provider is not liable for breaches of confidentiality caused by the member or any third party.
f. It is the member's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.
g. Member will receive an email and will reply to the email by typing their name as instructed and this will constitute an agreement when a signed document cannot be completed in person.

Cognitive Restructuring, LLC

TeleHealth Informed Consent Form

3. <u>Client Acknowledgement and Agreement</u>

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the services provided by electronic device or telephone between Cognitive Restructuring, LLC and me, and the conditions and instructions outlined, as well as any other instructions that my Provider or Therapist may impose to communicate with me by email or text.

Please mark <u>only</u> 1 choice below by initialing:

_____ I **wish** to receive TeleHealth Services provided by Cognitive Restructuring, LLC

_____ I **do not wish** to receive TeleHealth Services provided by Cognitive Restructuring, LLC

Client Name: ____

Client Signature: ______________________________ Date: ________________

Parent/Legal Guardian Name: ______________________

Parent/Legal Guardian Signature: ___________________ Date: ________________

Cognitive Restructuring, LLC

Employee Signature: ____________________________ Date: ________________

Cognitive Restructuring, LLC
Consent to Release and Exchange of Information

Cognitive Restructuring, LLC, will coordinate treatment with other behavioral health practitioners, primary care physicians (PCP's), family and/or other appropriate medical practitioners involved in a member's care. Please complete this form in full and we will send to the appropriate person(s) treating the member.

I,________________________________, hereby authorize Cognitive Restructuring, LLC
(Parent/Guardian of client or client name)

to request and/or disclose information, verbal or written, of

________________________ to ____
(Name of Client) (Name of Agency or Individual – Include Relationship)

____
(Contact Information Street Address City State Zip)

(Phone)______________________ (Company Fax number)______________________

*****Please X and initial next to all applicable items requested below (Questions ask Provider).**
The records requested are for the following services:

- ______ ☐ Substance/Alcohol Abuse Services
- ______ ☐ Case Management
- ______ ☐ RSS Services(Other)
- ______ ☐ Mental Health Services
- ______ ☐ HIV/AIDs related information
- ______ ☐ Legal Services

*****Please X and initial next to all applicable items requested below (Questions ask Provider).**
Specific Information Requested:

- ______ ☐ GAIN Assessment
- ______ ☐ Psychiatric Evaluation
- ______ ☐ Social/Medical History
- ______ ☐ History & Physical Exam
- ______ ☐ Laboratory Data(Drug Testing)
- ______ ☐ Probation/Parole Progress Reports
- ______ ☐ Medication Records
- ______ ☐ Admission/Discharge Summary
- ______ ☐ Court Related Information
- ______ ☐ Case Management Plans/Progress
- ______ ☐ Treatment Plans
- ______ ☐ Exchange Information
- ______ ☐ Other: ________________

 Revised 10/26/2021

Cognitive Restructuring, LLC

Consent to Release and Exchange of Information

The purpose of the disclosure authorized herein is to:____

(Purpose of disclosure, as specific as possible)

I understand the 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 (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed with my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any events this consent expires automatically 365 days post-discharge from the treatment program.

I also understand that this authorization is voluntary and that I my refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

______________________________	______________
Client Signature	Date
______________________________	______________
Parent/Guardian Signature	Date
______________________________	______________
Cognitive Restructuring Employee Signature	Date

BPA Clients Only

Idaho Substance Abuse Treatment and Recovering Support Services

Consent for Release of Information
I, ____________________, am requesting substance abuse services from Idaho's publicly funded substance system of care. As such I voluntarily authorize BPA Health, those Substance Abuse Treatment and Recovery Support Services (RSS) providers who are contracted to provide Treatment and RSS under Idaho's publicly funded substance abuse system of care, and the Department of Health and Welfare (Department) to disclose my name, all necessary treatment information and my social security number to each other and the Department. This information will be disclosed for the following purposes: **1)** To assist with referring me to appropriate types of care and guiding my treatment and recovery support; **2)** To be entered into the Department's common client database so that I will have one client number for any services received from the Department; **3)** To process payment of costs for my treatment and recovery support services; **4)** For monitoring compliance in the program; **5)** For programming audit and research including independent peer reviewers, contract monitors or researchers appointment by the Department; **6)** For investigations related to fraud. Furthermore, I authorize the disclosure of personal substance abuse treatment and recovery outcomes data collected by contracted Substance Abuse Treatment and RSS Providers, BPA Health and the Department to the Federal Center for Substance Abuse Treatment and its contracted data collections Agents.____, **Client initials**
Informed and Voluntary Consent for Treatment
The purpose of my participation, as a client, in the Idaho publicly funded substance abuse treatment program is to acquire knowledge, skills and attitudes supportive of a sober and more satisfying lifestyle. In addition to the potential positive outcomes likely to occur as a result of my participation, the following reasonably foreseen risks may occur, as they would in any other alcohol and drug treatment program: breach of confidentiality; negative reactions of group members; emotional stress from requirements of group interaction, self-disclosure; stress to relationships resulting from open discussion of issues, past traumas; and stress to relationships resulting from participant behavioral changes, positive or negative, need to attend recovery support meetings, spend time in group and doing assignments. Providers will take steps to minimize or protect participants against potential risks by adhering to standards of confidentiality found both in Federal and State Code, and by informing and verifying client understanding of group rules. And, by intervening in and guiding appropriate disclosure, confrontation and resolution in group and in family conflict. Providers will assist clients in accessing sober support services and self-help groups where acceptance and stress reducing support is available. _____, **Client initials.**
Revocation Clause
This release may be revoked at any time either orally or in some writing, except to the extent that action has already been taken in reliance on the release. I acknowledge that some information may include material that is protected by State and Federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Record, 42 C.F.R. Part 2 and the Health Information Portability and Accountability Act (HIPAA). Unless revoked as stated above, this consent expires automatically on: _____________. ______, **Client initials.**

Direct any and all questions or concerns to: Cognitive Restructuring, LLC

I have read above and Consent to Release of Information, Informed and Voluntary Consent for Treatment and the Revocation Clause. I agree I have been given the opportunity to question the above disclosures and consent for care and hereby do agree to the above identified Disclosure and Consent to Treatment.

Client Printed Name   Client Signature   Date

Parent/Guardian Printed Name   Parent/Guardian Signature   Date

Witness Printed Name   Witness Signature   Date

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

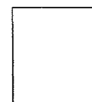
12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...



WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12
Self

In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do
H1	Overall, in the past 30 days, how many days were these difficulties present?				***Record number of days ____***	
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?				***Record number of days ____***	
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?				***Record number of days ____***	

This completes the questionnaire. Thank you.

PATIENT HEALTH QUESTIONNAIRE- 9
(PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? **Please Circle your response**	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING	0	±		±		±	
			= Total Score:				

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Please check your response below:

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Revised 10/26/2021

Behavioral Health-Health Questionnaire

Client's Name:	Today's Date:

Client's initial explanation of the problem(s), duration and precipitant cause:

Presenting problem/reason for assessment (In client's own words: list of symptoms or concerns of client):

Acuity Check

No	Yes	Do you have current, severe and/or untreated health problems?
No	Yes	Are there any Health concerns you currently have?
No	Yes	Do you feel that you are at risk for hurting yourself or someone else?
No	Yes	Are you being hurt by someone else or at risk of being hurt?
No	Yes	Have you just used any form of drugs or alcohol? When:

Medical

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

-Community Health Center -Urgent Care Center -Dentists -Private Community

-Physician Pain Management Services -Methadone Clinics -Hospital Emergency Rooms

-Specially Medicine (i.e. Immunization, Neurology, Cardiology, and Endocrinology)

General Health

1. Who is your Primary Care Physician?
2. What was date you were last seen?
3. How many times have you visited an Emergency Room in the past 30 days?
4. How many days in the past 30 have you stayed overnight in a hospital for physical health problems?
5. How many days in the past 30 have you experienced physical health problems?
6. Are you able to perform activities of daily living: bathing, shopping, cleaning, use of transportation?

PERTINENT HISTORY

(Including family, social, psychological and medical) Any prior therapy: Significant childhood developmental history (including mother's pregnancy and delivery, delays in meeting developmental milestones):

7. Significant childhood developmental history (including mother's pregnancy and delivery, delays in meeting developmental milestones):

8. Significant childhood social history (social delays, difficulty making or keeping friends)

9. Psychiatric/Behavioral History:

10. Childhood history (abuse, neglect, trauma):

11. Diagnosis in childhood (by whom, if applicable):

12. Age at onset:

13. Childhood psychiatric hospitalizations: (dates, reasons, symptoms of decompensation, medication):

14. History of any other illness that may require frequent medical attention. Give details:

MEDICAL HISTORY

15. List of Current Medications:

16. Current Medication Allergies:
17. Current Food Allergies:
18. Neurological Disorders (seizures, epilepsy, HI, stroke, Parkinson's, MS, Palsy, etc.):
19. Chronic diseases (HIV, hepatitis, etc.):
20. Remarkable family medical history (diabetes, cancer, heart disease):
21. Out-patient treatment (provider name, dates, modality):
22. Have you had any surgeries?
ADULT HISTORY
23. History of abuse as a perpetrator:
24. Diagnosis (by whom, if applicable):
25. Psychiatric hospitalization (dates, symptoms of decompensation, medications):
26. Out-patient treatment (provider, dates, modality):
27. History of malingering:
CURRENT MENTAL HEALTH DIAGNOSIS
28. (Diagnosis, date, diagnosed by:
FAMILY/PSYCHOSICIAL ASSESSMENT
29. Family Mental Health History (who, what, when):

30. Family (parents, Siblings, Children, etc.)

31. Current Service providers:

SUBSTANCE ABUSE

32. Indicate if GAIN is recommended:

33. Substance Use History (what, when, frequency, amount, impact on mental health)

34. Family History of drug/alcohol use: (what, when, frequency, amount, impact on mental health)

35. Substance Use Treatment (historical and current treatment, outpatient and inpatient, when, where, duration, outcome, treatment needs):

36. Drugs of choice (indicate C=current/P=past)

37. Current substance use/dependence (what and how often)

Alcohol Currently Sometimes Never

Illicit Drugs Currently Sometimes Never

38. Are you in withdrawal today? No Yes If yes, from what substance(s)?

39. Do you have frequent blackouts? No Yes How frequently?

40. Are you currently smoking/ingesting marijuana? No Yes Medical Marijuana Card? No Yes

41. Date last smoked/ingested:

42. Have you ever overdosed on alcohol or other drugs? No Yes if yes on what?
When?

43. Do you currently use tobacco? No Yes if yes, how? Smoking, Chewing, Other How much; (# Packs a day, # of dips)

44. Do you currently use a Vape? No Yes % of Nicotine

FUNCTIONAL ASSESSMENT

45. School/Education (current grade attending or highest grade completed/further education. (Diploma, GED, etc.)

46. Current and Previous Employment (full time/part time and names of employers, dates)

47. If unemployed: Currently seeking employment?

48. Military Service (active, inactive, veteran)

49. Needs:

FINANCIAL

50. Sources of Income

51. Skills for managing finances (budgeting, bill payment, etc.):

SOCIAL

52. Interests (leisure and recreational)
53. Support systems and relationships (Clients ability to establish and maintain support systems and relationships)
54. Level of social interaction
55. Needs:
BASIC LIVING SKILLS
56. Skills and abilities to meet age appropriate basic living skills (meal preparation, housekeeping, etc.):
57. Needs:
HOUSING
58. Current housing:
59. Level of satisfaction and stability:
60. History of housing stability:
61. Current Risk of homelessness:
62. Needs:

COMMUNITY
63. Transportation resources:
64. Identify membership in church, clubs, and other groups:
65. Do you have any religious, cultural, physical or other factors that might influence your care?
66. Needs:
LEGAL
67. History of criminal justice involvement (arrests, warrants, parole/probation or jail time):
68. Involvement with CPS:
69. Needs:
70. Are you experiencing any of the following: (Circle all that apply)

Ankles Swollen Bleeding Problems, Bruising easily Chest pain(angina) Cough; persistent or bloody Diarrhea, constipation, blood in stools Dizziness or fainting Fever	Headaches Jaundice-frequent yellowing of skin Joint pain or stiffness Excessive heartburn or Abdominal pains Chronic back pain Nausea and vomiting Rashes Seizures	Shortness of breath Sinus Problems Swallowing difficulty Thirst excessive Tooth or gum problems Urination frequent or bloody Vision-blurred or double vision Weight gain

71. Do you have or have you had any of the following: (Circle all that apply)

Arthritis Artificial Joint Asthma Emphysema Chronic bronchitis	Diabetes Anemia Blood Transfusions Cancer	Chemotherapy/Radiation High Blood Pressure Low Blood Pressure Stroke – if yes give details:

72. No Yes Head injury resulting in loss of consciousness? If yes, give details:

73. No Yes Heart Attack or Heart Problem? If yes, give details:

Date of heart attack:

Medical Interventions such as bypass, stint, etc.:

74. Women Only

No Yes Are you pregnant? Due Date:	Date of last period?
No Yes Breast feeding?	No Yes Any current or past domestic abuse?
No Yes Have you had any miscarriages or abortions?	No Yes Do you have pain with intercourse?
No Yes Do you have difficult periods?	No Yes Abnormal mammogram or lump? Date: No Yes Abnormal PAP? Date:
What age did you start your first period?	Date of last GYN exam:

75. Communicable Diseases

No Yes Have you ever been tested for TB?

No Yes Have you ever had a positive TB test? Date of last TB test or chest X-ray:

No Yes Have you been diagnosed with Hepatitis C? Date of last test:

No Yes Have you been tested for any other liver disease? Specify:

No Yes Have you been diagnosed with a Sexually Transmitted Infection (STI)?

No Yes Did you get treated? Date of last STI test:

Been tested for HIV? No Yes	Did you receive the test result? Been tested for HIV?	Date of last HIV Test?

Mental Health

76. How many times in the past 30 days have you received outpatient emergency services for mental health?

77. How many days in the past 30 have you stayed 24 hours or more in a hospital or psychiatric facility for mental health needs?		
78. No Yes In the past 30 days, have you taken prescribed medication for mental health needs, (including medication for anxiety-list on question 15).		
79. Past suicide attempts? No Yes	80. Date of most recent attempt:	81. How many attempts in your lifetime?
To the best of my knowledge, the above information is accurate and true, and I will inform my provider of changed in my health or medications: Client Signature: Date:		

ALERT® **Wellness Assessment - Adult**

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name ____________, First Name ____________ Date of Birth: (mm/dd/yy) __ / __ / __

Subscriber ID ____________ Authorization # ____________

Clinician Last Name ____________, First Name ____________ Today's Date: (mm/dd/yy) __ / __ / __

Clinician ID/Tax ID ____________ Clinician Phone ___ ___ - ____ State __ *MRef* O

Visit #: O 1 or 2 O 3 to 5 O Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	O	O	O	O
2. Feeling sad or blue	O	O	O	O
3. Feeling hopeless about the future	O	O	O	O
4. Feeling everything is an effort	O	O	O	O
5. Feeling no interest in things	O	O	O	O
6. Your heart pounding or racing	O	O	O	O
7. Trouble sleeping	O	O	O	O
8. Feeling fearful or afraid	O	O	O	O
9. Difficulty at home	O	O	O	O
10. Difficulty socially	O	O	O	O
11. Difficulty at work or school	O	O	O	O

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	O	O	O	O
13. I can deal with my problems	O	O	O	O
14. I am able to accomplish the things I want	O	O	O	O
15. I have friends or family that I can count on for help	O	O	O	O

16. In the past week, approximately how many drinks of alcohol did you have? ___ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: O Excellent O Very Good O Good O Fair O Poor
18. Please indicate if you have a serious or chronic medical condition:
    O Asthma O Diabetes O Heart Disease O Back Pain or Other Chronic Pain O Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? O None O 1 O 2-3 O 4-5 O 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ___ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ___ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? O Yes O No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? O Yes O No
24. In the past month have you felt bad or guilty about your drinking or drug use? O Yes O No

9626

Clinician: Please fax to (800) 985-6894

Rev. 2007

Authorization for Release of Information

Member's Name | Date of Birth | ☐ Member or Subscriber ID # ☐ Chart #

Member's Street Address | City | State | Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying Optum in writing. However, the revocation will not have an effect on any actions Optum took before it received the revocation.

I authorize Optum* to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

Name: ____________________

Address: ____________________

City | **State** | **Zip**

Phone Number: (___) _____Extension _____

*For purposes of this Authorization, "Optum" refers to the following Optum entities and respective subsidiaries, affiliates, and business divisions: United HealthCare Services, Inc.; Specialized Care Services, Inc.; Spectera, Inc.; Spectera of New York, IPA, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; United Resource Networks, Inc.; Special Risk International, Inc.; United Resource Networks IPA of New York, Inc.; EnvisionCare Alliance, Inc.; Specialty Resource Services, Inc.; National Benefit Resources, Inc.; Medical Network, Inc. d/b/a Health A to Z; DCG Resource Options, LLC; Disability Consulting Group, LLC; HealthAllies, Inc.; Distance Learning Network, Inc.; PacificDental Benefits, Inc.; Pacific Union Dental, Inc.; Nevada Pacific Dental; PacifiCare Dental; National Pacific Dental, Inc.; NPD Dental Services, Inc.; NPD Insurance Company, Inc.; ACN Group, Inc.; Managed Physical Network, Inc.; ACN Group IPA of New York, Inc.; ACN Group of California, Inc.; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; DBP Services of New York IPA, Inc.; Dental Benefit Providers of Maryland, Inc.; United Behavioral Health; U.S. Behavioral Health Plan, California; Behavioral Health Administrators; United Behavioral Health of New York, I.P.A., Inc.; PacifiCare Behavioral Health, Inc.; and PacifiCare Behavioral Health, Inc., of California.

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

☐ All
☐ Claims
☐ Eligibility/Benefits
☐ Information used to make benefit determinations
☐ All pertinent information Optum deems appropriate for the purpose checked below
☐ Other (describe): ____________________
☐ Treatment Plan(s)
☐ Progress Reports
☐ Attendance Only

The purpose of this authorization is (check all that apply):

☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.
☐ Benefit Management
☐ Claims Administration/Payment
☐ Employer Mandated Treatment Referral
☐ Other (describe): ____________________
☐ Administration of a Worker's Compensation claim
☐ Administration of a Disability claim
☐ Subpoena or other legal process

The dates of records to be disclosed:

From ___________(MM/DD/YYYY) To ___________(MM/DD/YYYY)

THE MEMBER OR MEMBER'S REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:

I understand that this authorization will expire:

☐ On ______________(MM/DD/YYYY) or one year from the date of the signature below (or as set forth in the applicable state-specific provisions below).

OR

☐ Once the following event occurs (***does not apply to Illinois residents***):

____

(Form must be completed before signing)

Signature of Member/Legal Guardian or Member's Representative	Signature of Minor Member	Date
Print Name of Member/Legal Guardian or Member's Representative	Relationship to Member	Description of Representative's Authority
(For Illinois residents only) Witness Signature		Date of Witness Signature

(***For California and Georgia residents only***) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

(***For California and Georgia residents only***) A copy of this form has been requested and received:
_____Yes _____No