|  |  |  |
| --- | --- | --- |
|  | Client Demographics | CC |
|  | **Provide Copy of your State ID, Driver’s License, or form of ID** | |
|  | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  | | | | | | | | | | Date |  | Referent | | | | | | | | | |  | | | | | |  |  | | | | | Client Name | | | | | |  | Client’s Provider One # & MCO | | | | |  | | |  | |  | | |  | |  | | Home Phone | | | | Cell phone | | | | | Can we leave a message | | |  | | | | | | | | | | | | Address or Mailing address connected to your MCO | | | | | | | | | | | |  | | |  | |  | | |  | |  | | City | | |  | | State. | | |  | | ZIP Code | |  | | | | | | | | | | | | Occupation/Business Type | | | | | | | | | | | |  | | | | | |  |  | | | | | DOB & AGE | | | | | |  | Gender | | | | |  | | | | | |  |  | | | | | DOC# & CCO Info or Lawyer info | | | | | |  | Service Requests | | | |   **If patient is going to receive Inhouse treatment get ROI for Emergency contact information available**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Emergency Contact Number Relationship, can we leave a Message** | |

**GENERAL CONSENT FOR CARE AND TREATMENT AGREEMENT TO THE PATIENT**

You have the right, as a patient, to be informed about your condition and the recommended Substance Use Treatment or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). as well as inhouse treatment services if you require IOP, or OP, and chose our treatment services for continued care.

This consent provides us with your permission to perform reasonable and necessary clinical assessment, and treatment recommendations, as well as continued care if choosing to do services with Axium Recovery Services. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; The consent will remain fully effective until it is revoked in writing, or you have been discharged from services or just accepted SUD Assessment Services from Axium Recovery Services and had recommendation faxed to any third party you provided. If admitted to Axium Recovery Services for IOP or OP treatment, you have the right at any time to discontinue services. You have the right to discuss the treatment plan with your professional about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request Axium Recovery Services), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary substance use assessment, and treatment for the condition which has brought me to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

[] **Check box if you have been giving a copy, I have been giving a copy of this information**,

**Printed Name** **of Patient** or Personal Representative

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

**Signature of Patient** or Personal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

If Representing Patient, Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Axium Recovery Services Practice and Procedures: WAC 246-341-0600- Clinical—Individual rights.**

(1) Each agency must protect and promote individual participant rights applicable to the services the agency is certified to provide in compliance with this chapter, and chapters [**70.41**](http://app.leg.wa.gov/RCW/default.aspx?cite=70.41), 71.05, 71.12, 71.24, and [**71.34**](http://app.leg.wa.gov/RCW/default.aspx?cite=71.34) RCW, as applicable.

(2) Each agency must develop a statement of individual participant rights applicable to the services the agency is certified to provide, to ensure an individual's rights are protected in compliance with chapters [**70.41**](http://app.leg.wa.gov/RCW/default.aspx?cite=70.41), 71.05, 71.12, 71.24, and [**71.34**](http://app.leg.wa.gov/RCW/default.aspx?cite=71.34) RCW, as applicable. To the extent that the rights set out in those chapters do not specifically address the rights in this subsection or are not applicable to all of the agency's services, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:"

(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability.

(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice.

(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited-English proficiency, and cultural differences.

(d) Be treated with respect, dignity, and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises or to address risk of harm to the individual or others. "Reasonable" is defined as minimally invasive searches to detect contraband or invasive searches only upon the initial intake process or if there is reasonable suspicion of possession of contraband or the presence of other risk that could be used to cause harm to self or others.

(e) Be free of any sexual harassment.

(f) Be free of exploitation, including physical and financial exploitation.

(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations.

(h) Participate in the development of your individual service plan and receive a copy of the plan if desired.

(i) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections; and

(j) Submit a report to the department when you feel the agency has violated a WAC requirement regulating behavioral health agencies.

(3) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:

(a) Provided in writing to each individual on or before admission.

(b) Available in alternative formats for individuals who are visually impaired.

(c) Translated to the most commonly used languages in the agency's service area.

(d) Posted in public areas; and

(e) Available to any participant upon request.

(4) At the time of admission and upon client request, the agency must provide each client with information on how to file a report to the department if they feel their rights or requirements of this chapter have been violated.

**Check box if you agree with participating in the development of your ISP at least once a month with Primary Counselor. This individual service plan reflects your preferences and priorities. You received information about diagnoses and available treatment options including the option of no treatment at all and the risks and benefits. You received information about your right to participate in your health care decisions, including your right to refuse treatment. Your signature below indicates agreement with this service plan and that you received a copy.**

**Grievance Process:** Should you ever have concerns about our services, we encourage you to first discuss these concerns with Clinical Supervisor. Should you feel that you cannot resolve your concerns by talking with us directly, we encourage you to contact. If you do not feel comfortable providing a staff member with this feedback directly, please feel free to contact:

**State Contact Information:** Department of HealthCounselor Programs: P.O. Box 47869. Olympia, WA 98505-7869 (360) 664-9098

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

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

**Medicaid participants 182-538-180 Rights and Protections (1 of 2)**

Individuals who apply and are eligible for Medicaid-funded health care services have Medicaid specific rights under [WAC 246-341-0600](https://apps.leg.wa.gov/wac/default.aspx?cite=246-341-0600).

* Individuals who apply and are eligible for Medicaid-funded health care services have Medicaid specific rights.
* Individuals with Medicaid-funded insurance have participant rights under [WAC 246-341-0600](https://apps.leg.wa.gov/wac/default.aspx?cite=246-341-0600).
* Participants may ask for help with completing and submitting forms to the agency.
* Participants may ask for help with giving and receiving the information that the agency needs in order to decide continuing eligibility.
* Participants may ask for help with requests continuing benefits.
* Participants may ask for help with the assistance of explaining the reduction in or ending of benefits.
* Participants may ask for assistance with requests for administrative hearings.
* On request, participants may ask for assistance in reviewing the agency's decision to terminate, suspend, or reduce benefits.
* Participants may receive the name, address, telephone number, and any languages offered other than English of providers in a managed care organization (MCO).
* Participants may receive information about the structure and operation of the MCO and how health care services are delivered.
* Participants may receive emergency care, urgent care, or crisis services.
* Participants may receive post stabilization services after receiving emergency care, urgent care, or crisis services that result in admittance to a hospital.
* Participants may receive age-appropriate and culturally appropriate services.
* Participants may ask to be provided with a qualified interpreter and translated material at no cost to the individual.
* Participants may request to receive information and help in the language or format of their choice.
* Participants may have an explanation of alternative treatment options and alternative treatment options.
* Participants may refuse any proposed treatment option.
* Participants have the right to receive care that does not discriminate.
* Participants have the right to receive care that is free of any sexual exploitation or harassment.
* Participants may create an advance directive that states the individual’s choices and preferences for health care services under 42 C.F.R. Sec. 489 Subpart I.
* Participants may choose their own contracted health care provider.
* Participants may request and receive a copy of their health care records.
* Participants may be informed if there is a cost for copies.
* Participants have the right to be free from retaliation.
* Participants my request to receive the policies and procedures of the MCO as they relate to health care rights.
* Participants have the right to receive services in an accessible location.

**Medicaid participants 182-538-180 Rights and Protections (Continued 2 of 2)**

* Participants may receive medically necessary services in accordance with the early and periodic screening, diagnosis, and treatment (EPSDT) program under [WAC 182-534-0100](https://apps.leg.wa.gov/wac/default.aspx?cite=182-534-0100), if the individual is age twenty or younger.
* Participants have the right to be treated with dignity, privacy, and respect.
* Participants have the right to receive treatment options and alternatives in a manner that is appropriate to the individual’s condition.
* Participants have the right to be free from seclusion and restraint.
* Participants may receive a second opinion from a qualified health care professional within an MCO provider network at no cost or having one arranged outside the network at no cost, as provided in 42 C.F.R. Sec. 438.206(b)(3).
* Participants may receive medically necessary health care services outside of the MCO if those services cannot be provided adequately and timely within the MCO.
* Participants have the right to file a grievance with an MCO if the individual is not satisfied with a service provided.
* Participants may receive a notice of action in order to appeal any decision by the MCO.
* Participants may appeal an MCO decision that Denies or limits authorization of a requested service.
* Participants may appeal an MCO decision that reduces, suspends, or terminates a previously authorized service.
* Participants may appeal an MCO decision that denies payment for a service, in whole or in part.
* Participants have the right to file an appeal if the MCO fails to provide health care services in a timely manner as defined by the state or act within the time frames in 42 C.F.R. Sec. 438.408(b).
* Participants have the right to request an administrative hearing if an appeal is not resolved in a person's favor.

**Grievance Process:** Should you ever have concerns about our services, we encourage you to first discuss these concerns with Clinical Supervisor. Should you feel that you cannot resolve your concerns by talking with us directly, we encourage you to contact. If you do not feel comfortable providing a staff member with this feedback directly, please feel free to contact:

**State Contact Information:** Department of Health

Counselor Programs: P.O. Box 47869. Olympia, WA 98505-7869 (360) 664-9098

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

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

**RCW**[**71.24.585**](http://app.leg.wa.gov/RCW/default.aspx?cite=71.24.585)

**Opioid and substance use disorder treatment—State response. (1 of 2)**

(1)(a) The state of Washington declares that substance use disorders are medical conditions. Substance use disorders should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence, including medications approved by the federal food and drug administration for the treatment of opioid use disorder. It is also recognized that many individuals have multiple substance use disorders, as well as histories of trauma, developmental disabilities, or mental health conditions. As such, all individuals experiencing opioid use disorder should be offered evidence-supported treatments to include federal food and drug administration approved medications for the treatment of opioid use disorders and behavioral counseling and social supports to address them.

**For behavioral health agencies**, an effective plan of treatment for most persons with opioid use disorder integrates access to medications and psychosocial counseling and should be consistent with the American society of addiction medicine patient placement criteria. Providers must inform patients with opioid use disorder or substance use disorder of options to access federal food and drug administration approved medications for the treatment of opioid use disorder or substance use disorder. Because some such medications are controlled substances in chapter [**69.50**](http://app.leg.wa.gov/RCW/default.aspx?cite=69.50) RCW, the state of Washington maintains the legal obligation and right to regulate the uses of these medications in the treatment of opioid use disorder.

(b) The authority must work with other state agencies and stakeholders to develop value-based payment strategies to better support the ongoing care of persons with opioid and other substance use disorders.

(c) The department of corrections shall develop policies to prioritize services based on available grant funding and funds appropriated specifically for opioid use disorder treatment.

(2) The authority must promote the use of medication therapies and other evidence-based strategies to address the opioid epidemic in Washington state. Additionally, by January 1, 2020, the authority must prioritize state resources for the provision of treatment and recovery support services to inpatient and outpatient treatment settings that allow patients to start or maintain their use of medications for opioid use disorder while engaging in services.

(3) The state declares that the main goals of treatment for persons with opioid use disorder are the cessation of unprescribed opioid use, reduced morbidity, and restoration of the ability to lead a productive and fulfilling life.

(4) To achieve the goals in subsection (3) of this section, to promote public health and safety, and to promote the efficient and economic use of funding for the Medicaid program under Title XIX of the social security act, the authority may seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis.

(5) The authority must partner with the department of social and health services, the department of corrections, the department of health, the department of children, youth, and families, and any other agencies or entities the authority deems appropriate to develop a statewide approach to leveraging Medicaid funding to treat opioid use disorder and provide emergency overdose treatment. Such alternative sources of funding may include:

(a) Seeking a section 1115 demonstration waiver from the federal centers for Medicare and Medicaid services to fund opioid treatment medications for persons eligible for Medicaid at or during the time of incarceration and juvenile detention facilities: and

(b) Soliciting and receiving private funds, grants, and donations from any willing person or entity.

**Opioid and substance use disorder treatment—State response. (2 of 2)**

(6)(a) The authority shall work with the department of health to promote coordination between medication-assisted treatment prescribers, federally accredited opioid treatment programs, substance use disorder treatment facilities, and state-certified substance use disorder treatment agencies to:

(i) Increase patient choice in receiving medication and counseling.

(ii) Strengthen relationships between opioid use disorder providers.

(iii) Acknowledge and address the challenges presented for individuals needing treatment for multiple substance use disorders simultaneously; and

(iv) Study and review effective methods to identify and reach out to individuals with opioid use disorder who are at high risk of overdose and not involved in traditional systems of care, such as homeless individuals using syringe service programs, and connect such individuals to appropriate treatment.

(b) The authority must work with stakeholders to develop a set of recommendations to the governor and the legislature that:

(i) Propose, in addition to those required by federal law, a standard set of services needed to support the complex treatment needs of persons with opioid use disorder treated in opioid treatment programs.

(ii) Outline the components of and strategies needed to develop opioid treatment program centers of excellence that provide fully integrated care for persons with opioid use disorder.

(iii) Estimate the costs needed to support these models and recommendations for funding strategies that must be included in the report.

(iv) Outline strategies to increase the number of waivered health care providers approved for prescribing buprenorphine by the substance abuse and mental health services administration; and

(v) Outline strategies to lower the cost of federal food and drug administration approved products for the treatment of opioid use disorder.

(7) State agencies shall review and promote positive outcomes associated with the accountable communities of health funded opioid projects and local law enforcement and human services opioid collaborations as set forth in the Washington state interagency opioid working plan.

(8) The authority must partner with the department and other state agencies to replicate effective approaches for linking individuals who have had a nonfatal overdose with treatment opportunities, with a goal to connect certified peer counselors with individuals who have had a nonfatal overdose.

(9) State agencies must work together to increase outreach and education about opioid overdoses to non-English-speaking communities by developing a plan to conduct outreach and education to non-English-speaking communities. The department must submit a report on the outreach and education plan with recommendations for implementation to the appropriate legislative committees by July 1, 2020

**Grievance Process:** Should you ever have concerns about our services, we encourage you to first discuss these concerns with Clinical Supervisor. Should you feel that you cannot resolve your concerns by talking with us directly, we encourage you to contact. If you do not feel comfortable providing a staff member with this feedback directly, please feel free to contact:

**State Contact Information:** Department of Health

Counselor Programs: P.O. Box 47869. Olympia, WA 98505-7869 (360) 664-9098

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

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

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

**I am required to tell you about this because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).** In most situations I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law or HIPAA. This notice will tell you about how I handle information about you. It tells how I use this information in my office, how I share it with other professionals and organizations, and how you can see it.

The information I obtain from you goes into your medical record at my office. It is likely to include the following: • Your personal history; • Reasons you came for treatment: problems, symptoms, needs, goals; • Diagnoses: medical terms for your problems, symptoms, disabilities; • Treatment Plan: services that I think will help you; • Progress Notes; • Records from others who treated or evaluated you if applicable; • Psychological test scores, school records, and the like; • Information about medications you are taking; • Legal matters; and • Billing and insurance information. Medical information is used for many purposes.

For example, I may use it to: • Plan your care; • Decide how well my treatment is working for you; • Talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to me; and • Show that you actually received the services from me that I billed to you or your health insurance company. How Protected Health Information Can Be Used and Shared. When your information is read by me or others, it is called “use.” If the information is shared with or sent to others outside this office, it is called “disclosure.” Except in some special circumstances, when I use your PHI or disclose it to others, I share only the minimum necessary PHI needed for the purpose.

The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed. Use or disclosure of the following protected health information does not require your consent of authorization:

**(1).** Uses and disclosures required by law - like files court-ordered by a Judge; **(2).** Uses and disclosures about victims of abuse, neglect, or domestic violence - like the duties to warn explained in the Disclosure Statement; **(3).** Uses and disclosures for health and oversight activities - like correcting records or correcting records already disclosed; **(4).** Uses and disclosures for judicial and administrative proceedings - like a case where you are claiming malpractice or breech of ethics; **(5).** Uses and disclosures of law enforcement purposes - like if you intend to harm someone else; **(6).** Uses and disclosures to avert a serious threat to health or safety - like calling Probate Court for a commitment hearing; and/or **(7).** Uses and disclosures for Worker’s Compensation - like the basic information obtained in therapy/counseling as a result of your Worker’s Compensation claim.

**I acknowledge that I have received a copy and have read and understand Client’s Rights and HIPAA Client’s Rights and protocol for who, what, when and how to make a complaint and my rights.**

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

Printed name of Patient Signature of Patient Date

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Staff                                        Date

**Your Rights as a Patient under HIPAA**

**(1).** As a client, you have the right to see your file, unless it would endanger your health or another person’s health or safety. Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right. (**2).** As a client, you may obtain a copy of your treatment, or a summary of your treatment. There is a standard administrative fee for copies; a fee for a treatment summary may apply. (**3)**. As a client, you have the right to request amendments to your counseling/therapy file. (**4)**. As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees @ $.05 a page as well as a fee for my time.

**(5)**. As a client, you have the right to restrict the use and disclosure of your PHI for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed. (**6)**. As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated. Prior to your treatment, you will receive an exact duplicate of these pages and the Professional Disclosure Statement.

It will be necessary for you to sign a certificate indicating that you have received, read, and understood both documents. This certificate will be placed in your file**. Please do not sign the certificate if you do not understand any part of the HIPAA Client’s Rights of the Professional Disclosure Statement**. I will be happy to explain these documents further.

In summary, HIPAA and Washington State law provide you with certain rights regarding your clinical record and disclosure of protected health information about you. These rights include: • Requesting that I amend your record; • Requesting restrictions on what information from your clinical record is disclosed to others; • Requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; • Determining the location to which protected information disclosures are sent; • Having any complaints you make about my policies and procedures recorded in your records; and • Receipt of a copy of this Notice of Privacy Practices form.

**If you suspect that my conduct has been unprofessional in any way, please contact:**

**Department of Health**

Counselor Programs

P.O. Box 47869

Olympia, WA 98505-7869

(360) 664-9098

**I acknowledge that I have received a copy and have read and understand Client’s Rights and HIPAA Client’s Rights** **and protocol for who, what, when and how to make a complaint and my rights.**

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

Printed name of Patient Signature of Patient Date

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

Staff                                        Date

**Confidentiality:** There is a legal privilege in this state that protects any information that you share with me and requires me to keep the strictest of confidentiality (See HIPAA consent form). As a professional, I assure you that I maintain strong ethical standards of confidentiality. There are legal exceptions to this confidentiality. The following situations are ones in which the information you have shared with me may be given to others: **(1)** suspected abuse of a child, developmentally disabled person, or a dependent adult; **(2)** potential suicidal behavior; **(3)** threatened harm to another, which may include knowledge that the client is HIV positive when there is an unwillingness to inform individuals with whom the client is intimately involved; and **(4)** when required by court order. Information may also be disclosed if a client signs a written release authorizing said disclosure or if a complaint is filed by the client against the counselor. If insurance is sought, confidentiality is waived. No records will be released without written permission on a Release of Information Form or a Court Order.

**Title 42 of the Code of Federal Regulations (CFR) Part 2:** Confidentiality of Substance Use Disorder Patient Records (Part 2) was first promulgated in 1975 to address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment-based settings such as administrative or criminal hearings related to the patient. Part 2 is intended to ensure that a patient receiving treatment for a SUD in a Part 2 Program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings such as those related to child custody, divorce, or employment. Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders can disclose such records. Part 2 Programs are federally assisted programs. In general, Part 2 Programs are prohibited from disclosing any information that would identify a person as having or having had a SUD unless that person provides written consent. Part 2 specifies a set of requirements for consent forms, including but not limited to the name of the patient, the names of individuals/entities that are permitted to disclose or receive patient identifying information, the amount and kind of the information being disclosed, and the purpose of the disclosure (see §2.31). In addition to Part 2, other privacy laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA)5 have been enacted. HIPAA generally permits the disclosure of protected health information for certain purposes without patient authorization, including treatment, payment, or health care operations.

***Consultations****:* I regularly consult with other professionals and supervisors to gain further knowledge and skill on how to help my clients. Such discussions are done so in a way to maintain confidentiality.

**Unprofessional Conduct:** The state brochure called “Counseling or Hypnotherapy Clients” lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the address and phone number on the following page.

**State Contact Information:**

Department of Health Counselor Programs

P.O. Box 47869. Olympia, WA 98505-7869 (360) 664-9098

I acknowledge that I have received a copy and have read and understand client’s **Confidentiality**, **Title 42 of the Code of Federal Regulations (CFR) Part 2,** as well as **Unprofessional Conduct protocol,** for who, what, when, and how to make a complaint and my rights.

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

Printed name of Patient Signature of Patient Date

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Staff                                        Date

**Disclosure Statements:** Sherman Robinson Jr. BS, SUDP, MRT, DV, SAP **&** Tiffany Mullin, M.Ed., VRC, BSW, SUDP, MRT **&** Mitchell Eggett. MRT, CPC, Peer Support Specialist.

**Mr. Robinson’s Education and Training:** DOT SAP Certified, Graduate Certificate for Contemporary Theory in Mental Health & Clinical Supervising, Bachelor’s degree in Human Service, Psychology, Addiction Studies, MRT, DV, & continues his Graduate studies in Clinical Mental Health Counseling at Capella University, currently holds a Washington State Substance Use Dependence Professional License **# CP60784743.**

**Clientele, Services, and Techniques**: Has extensive experience implementing evidence-based theories and comprehensive therapy techniques which best suit the individual client’s needs; Motivational Interviewing, Person-Centered, Solution-Focused, Solution Orientated, CBT, DBT, REBT, MRT, Anger Management & DV, as well as working with individuals with co-occurring issues.

**Ms. Mullin’s Education and Training:** Master’s Degree in Adult Education, Specializing in Disabilities and Vocational Rehabilitation Counseling a Bachelor’s in Social Work and Public Services Administrations, Associates in Addiction Services, MRT & Anger Management certified currently holds a Washington State Substance Use Dependence Professional License **# CP60969079**

**Clientele, Services, and Techniques**: For over 20 years, has worked in professional settings as a program coordinator, specializing in ADA compliance on the job and case manager as a contracted provider with DSHS as well as over 5 years of continued work & education in the Addiction Field.

**Mr. Eggett’ s Education and Training:** CPC Certified, MRT & Anger Management Certified, Peer Support Specialist. & Group Facilitator, Is an Ambassador of Hope and Recovery, holding hope for the clients until they can find it for themselves, with the ability to empathize his lived experience. Currently attending College for Addition Studies, with the objective to become a Great SUDP Counselor.

**Payment and Scheduling Policy:** The fee for services is arranged through client’s insurance or third-party payees. Scale fees can be arranged if clients have insurance coverage or partial coverage and will be discussed at intake. We will not terminate services due to nonpayment unless client request termination. **Client will be discharged** if there is no contact with office after **3 consecutive no call/ no show scheduled appointments**, and all parties related to client’s continued care requiring status reporting will be notified as needed. There are no refunds unless client has pre-paid for sessions as arranged and any sessions not attended with notice will be refunded by mail to **address on file** within 7 business days. Please makes sure to update your address and demographic information with us as needed, **it is your responsibility.**

Frequent schedule changes result in disruptive work and are discouraged. If you do not schedule for four consecutive weeks, we will assume you are terminating your work with use. We take vacation a few times a year and observe major holidays. We will inform you as well as post this office closures on client bulletin board located in front office.

**Insurance Information:** We accept Apple Health & MCO Payments. Arrangement will be made if needing Sliding Fee.

**Confidentiality:** There is a legal privilege in this state that protects any information that you share with me and requires me to keep the strictest of confidentiality (See HIPAA consent form). As a professional, I assure you that I maintain strong ethical standards of confidentiality but there are limitations,

**Unprofessional Conduct & Grievance:** The state brochure called “Counseling or Hypnotherapy Clients” lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact:

**State Contact Information:**

Department of Health Counselor Programs P.O. Box 47869 Olympia, WA 98505-7869 (360) 664-9098

**Contacting us by Phone:** Office phone or voice messages will be returned within 24 hours of delivery of business day.

**Emergencies:** If you are in a general emergency and cannot reach me, Emergencies: 911 Crisis Clinic: (800) 244-5767

I have read and understand the information presented in this form.

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

Printed name of Client Signature of Client                                    Date

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

Printed name of Counselor Signature of Counselor                    Date

**Unprofessional Conduct (1 of 2)**

Axium Recovery Services is obligated by law to provide each presenting client their disclosure law, this law regulates counselor, and provides protection for public health and safety, and to empower the client/patient by providing a complaint process against counselors who commit acts of unprofessional conduct. Patients/ clients have the right to choose counselors who best suit their needs and purposes.

The extent of confidentiality provided by RCW 18.19.180 (1) through (6). Note. Federal confidentiality regulations satisfy this requirement. Patients are to be provided a list or copy of the act of unprofessional conduct in RCW 18.130.180 address and phone provided below. **Counselors are subject to discipline by the Department of Health, Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:If you do not feel comfortable providing a staff member with this feedback directly, please feel free to contact:

**State Contact Information:**

Department of Health

Counselor Programs

P.O. Box 47869

Olympia, WA 98505-7869

(360) 664-9098

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence are conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter [**9.96A**](http://app.leg.wa.gov/RCW/default.aspx?cite=9.96A) RCW.

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof.

(3) All advertising which is false, fraudulent, or misleading.

(4) Incompetence, negligence, or malpractice which results in injury to a patient, or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction.

(6) Except when authorized by \*RCW [**18.130.345**](http://app.leg.wa.gov/RCW/default.aspx?cite=18.130.345), the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items. (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority.

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder.

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority.

(10) Aiding or abetting an unlicensed person to practice when a license is required.

**Unprofessional Conduct (Continued 2 of 2)**

(11) Violations of rules established by any health agency.

(12) Practice beyond the scope of practice as defined by law or rule.

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession.

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk.

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health.

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service.

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter [**9.96A**](http://app.leg.wa.gov/RCW/default.aspx?cite=9.96A) RCW.

(18) The procuring, or aiding or abetting in procuring, a criminal abortion.

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority.

(20) The willful betrayal of a practitioner-patient privilege as recognized by law.

(21) Violation of chapter [**19.68**](http://app.leg.wa.gov/RCW/default.aspx?cite=19.68) RCW.

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of: (a) Alcohol. (b) Controlled substances; or (c) Legend drugs.

(24) Abuse of a client or patient or sexual contact with a client or patient.

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

(26) Violation of RCW [**18.130.420**](http://app.leg.wa.gov/RCW/default.aspx?cite=18.130.420);

(27) Performing conversion therapy on a patient under age eighteen.

Axium Recovery Services adherence to the Ethical Principles of the American Psychological Association. Should you ever have concerns about our services, we encourage you to first discuss these concerns with Clinical Supervisor. Should you feel that you cannot resolve your concerns by talking with us directly, we encourage you to contact.

**State Contact Information:**

Department of Health

Counselor Programs

P.O. Box 47869

Olympia, WA 98505-7869

(360) 664-9098

**I have read and understand the information presented in this form.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_

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

Axium Recovery Services Patient Disclosure Information

The following paragraphs answer some important questions concerning our services. If you have questions after reading this information, or if you have other concerns not addressed here, please direct your questions or concerns to your counselor. Read all this information carefully—it will save you time when you meet with your counselor. Please be aware that while service animals are welcome in our clinics, other animals are not allowed. This stance was adopted out of concern for students and staff with allergies.

Information about your first appointment Your first meeting with a counselor will either be a walk-in or an assessment interview. During this meeting, you will be able to share with the counselor your concerns and feelings. The goal of this meeting will be for you and your counselor to develop a plan to address your concerns. The best plan to meet your needs might involve returning to see this same counselor again; it might involve referral to a different counselor on our staff; it might involve group treatment; or it might involve being referred to some other community resource. Your counselor may be able to share a plan with you at the end of your meeting, or Counseling Service staff may need to consult and get back to you via phone with a plan.

To best meet the needs of the many, Axium Recovery Services treatment programs are between 1 thru 12 months, although some receive more. At times during the year, we may have a waiting list for ongoing appointments. Individuals in crisis are always given top priority for appointments. We refer clients who need more long-term treatment to community resources. Your counselor will talk with you more about these issues if necessary.

**Informed Consent of Fee Schedule for SUD Treatment *and* Sliding Scale Fees (SSF) for low income & Uninsured.**

* + SUD Assessment $132.45- 24% off for SSF Minimum charge of $100.00
  + Group Therapy Session $83.26 (10 units) (1st 30 min. 2-unit $16.70) ($8.32 unit each 15 min. thereafter)- 50% off SSF Minimum charge of $42.00 per session
  + Individual Therapy Session $88.60 -28% off SSF Minimum charge of $25.00 per session
  + UA lab work - Minimum charge of SSF $30.00 \* waved if doing Assessment.
  + DUI Assessments -$100.00 & $30.00 UA Test @ time of Assessment.
  + ADIS Class -$100.00 - 8-hour Class with Certificate at completion
  + DOL SAP Assessment & Follow-Up -$350.00

**Confidentiality** **& Limitations:** WAC 388-101D-0125; WAC 246-180-031 & RCW 18.19.180 Axium Recovery Services is obligated to provide each presenting client their **Disclosure Statement** as well assure the client has a good understanding and acknowledges their **Clinical -Individual Rights WAC 246-341-0600; Medicaid Participants 182-538-180; Rights and Protections, Axium’s Confidentiality & Limitations**, **Mandatory Reporting** & **42CFR Part 2**, **HIPPA Rights** & **Unprofessional Conduct** & **Grieving Procedures,** as well as providing brief education, prevention and any needed resources and recommendation for **HIV/AIDS, Bloodborne & Air Borne Pathogens (TB) Intervention, Medical or Bio-Medical concerns.**

**Client’s Expectations Group Rules**: All information can also be read in Front Office Bulleting Board and copies can be issued if your intake copies are lost.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

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

Axium Recovery Services Patient Disclosure Information

All counseling services are confidential. In general, no information is released to individuals outside the Counseling Service without your consent. There are certain exceptions to this rule, as permitted by law and professional ethics. Our experience is that these exceptions arise infrequently. They include:

a. We may disclose confidential information when we judge that there is a strong possibility of serious harm being inflicted by you on another person or on yourself and we are unable to develop a plan with you to ensure safety.

b. Should you disclose information relating to probable child abuse, elder abuse, or abuse of a vulnerable adult (for example, someone who is developmentally disabled or mentally ill, or who has a disabling illness), we may be required to notify state authorities. Also, should you be over the age of 18 and engaging in sexual activities with someone under the age of 18, we may be required to report this matter to state authorities.

c. Court subpoena relevant records from our agency should our staff become the subject of a complaint. If a client files a complaint or lawsuit against the Counseling Service, we may disclose relevant information regarding that client—so that we may provide our side of the circumstances in dispute.

d. Should you be involved in legal proceedings that are related to your counseling concerns, the court might subpoena your records and/or our testimony could be required. In such cases, we will work to ensure your rights are protected.

e. If you file a worker’s compensation claim, this constitutes authorization for us to release your relevant mental health records to involved parties and officials.

f. We may be required to disclose your health information, without your knowledge, to authorized federal officials who are conducting national security and intelligence activities.

g. Should you die, the personal representative of your estate will have a legal right to access your treatment records. If you have not appointed a representative, your relatives may gain access to your records.

h. Additional limitations on confidentiality apply to students under the age of 18. If you are under 18, your counselor will discuss these limitations with you.

Counseling staff may consult with one another or receive supervision on specific cases from other professionals. All such consultations are conducted with your written consent, to improve the quality of services offered to you. Any counseling professional who provides us with consultation or supervision is obligated to hold information in confidence. Your consent is only required at the beginning of your services for Axium Staff to converse with each other when consultation occurs.

Also, when a client is being treated as a client/patient in more than one clinic, staff may verbally consult with each other to coordinate care and improve the quality of services. Your consent is not required for this consultation to occur. All Axium Recovery Services staff adhere to the ethics of healthcare providers and are obligated to keep patient information confidential, with the exceptions listed above.

Records of your contacts with our office are maintained by your counselor. These records are held secure and confidential and will be released only with your prior written consent (with the same exceptions as above). You generally have the right to a copy of the records in your file. Requests to access your file should be directed to your counselor.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

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

**Social Media Policy**: Clinicians, Staff, & Volunteers, do not follow or accept friend or contact requests from current or former clients on any social networking site other than **www**.**axiumservice.com,** as it can compromise confidentiality and therapeutic boundaries. The Counseling Service staff do not accept texting, SMS, or messaging. Such platforms are not secure, and we are not set up to interact on them in a timely way.

**24-hour Video Surveillance: For your protection as well as the Staff.**

**Service availability** Axium Services is open for client’s contact from 9:00 a.m. to 7:30 p.m., Monday thru Friday and 9:00am to 1:00pm on Saturday. Please be aware that even when our office is open, our desk is not always staffed. So, while you are always welcome to leave phone messages on our voice mail (509-474-1148), it may take some time (even hours) for us to retrieve your message and return your call. But all calls messages will be answered within 24 hours of business day after leaving message. Website: [www.axiumservice.com](http://www.axiumservice.com)

After-hours Crisis Counseling Service to provide clients with support when the Counseling Service is closed.

**Regional crisis line at: 1-877-266-1818.**

You can also call one of the following resources:

Washington Suicide & Crisis Hotline**: 1-877-968-8454**

The Washington Recovery Help line: **1-866-789-1511**

If you have a life-threatening emergency**, call 911.** For non-life threating resources**: 211**

What if I am unable to make it to an appointment?

If you are unable to keep an appointment with our staff, call **509-413-2516** to cancel as far in advance as possible. If you report to a third party for legal issues, it is your responsibility to inform them of your absent.

If you no-show without canceling, we will try and contact you by phone only leaving a message if necessary if given written permission to protect your privacy.

If you are repeatedly no-show, you may lose your slot on your counselor’s schedule and could be discharged for lack of attendance, so it is important to stay in contact, when possible and make sure if there is a third party (DOC, PO’s, Courts ext..) who you are required to report your treatment compliance include them in reaching out, letting them know why you are not attending your requirements and documented for your records.

I have read and understand the information presented in this form and have been offered a copy.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_

Admit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_

**HIV, OTHER BLOODBORNE PATHAGINS, TB & COVID-19.**

**HIV is a virus**, while [AIDS](https://www.everydayhealth.com/hiv/guide/complications/) is a stage of advanced infection. Specifically, HIV, or the human immunodeficiency virus, is an infectious virus that gradually breaks down a person’s immune system, HIV is spread through contact with certain body fluids from a person with HIV. These body fluids include: The spread of HIV from person to person is called HIV transmission. The spread of HIV from a woman with HIV to her child during pregnancy, childbirth, or breastfeeding is called mother-to-child transmission of HIV.

HIV can only be transmitted from an infected person to another through direct contact of bodily fluids such as: Blood contains the highest concentration of the virus, followed by semen, followed by vaginal fluids, followed by breast milk. Unprotected sex and shared needles are High Risk activities associated in SUD community.

**Bloodborne pathogens** are microorganisms in human blood or certain body fluids that cause disease in humans. The most common ones are the hepatitis B virus (HBV), which causes a severe form of Hepatitis in some or acts as a carrier in others, and the human immunodeficiency virus (HIV), which causes AIDS.

Bloodborne pathogens may be passed on when the microorganisms enter the body through mucus membranes, through breaks in the skin or through needle sticks. In non-medical occupations, exposure is most common when an injured worker’s blood contacts a co-worker rendering first aid. Practicing universal precautions and wearing the proper personal protective equipment will prevent exposure. Universal precautions are methods of preventing infection by treating all human body fluids as if they were contaminated and using proper personal protective equipment whenever you are required to encounter these fluids.

**Tuberculosis (TB)** is an infectious disease caused by bacteria. TB most commonly affects the lungs but also can involve almost any organ of the body. Tuberculosis is caused by bacteria that spread from person to person through microscopic droplets released into the air. This can happen when someone with the untreated, active form of tuberculosis coughs, speaks, sneezes, spits, laughs or sings.

**Coronavirus disease (COVID-19)** is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it is important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow). The best way to prevent and slow down transmission is to be well informed about the COVID-19 virus, the disease it causes and how it spreads. Protect yourself and others from infection by washing your hands or using an alcohol-based rub frequently and not touching your face.

For any concerns or testing you can contact Spokane County Reginal Health for further assistance at **1101 W. College Ave. Spokane, WA 99201 (509)324-1500, or discuss with your PPC. My signature below confirms that I understand and Read HIV, Bloodborne Pathogen’s & TB information and will be required to cover more while being a client at Axium Recovery Services as well as been giving a copy of this agreement.**

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

Printed name of Patient Signature of Patient Date

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

StaffDate

CONSENT TO RELEASE RECORDS CONTAINING SUBSTANCE ABUSE INFORMATION 42 CFR Part 2 and HIPAA REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure. Your organization needs to verify this release and your processes are compliant with 42 CFR.

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,**

(Patient Name, DOB, Provider One#)

Authorize, **Axium Recovery Services** to disclose any documentation in my file needed for claim submission including but not limited to, demographics, to my managed care organization and WA State Health Care Authority (listed below) or commercial payer, circled below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **WA State HealthCare Authority**  Cherry street plaza 626 8th Ave. SE Olympia, WA 98501 | **Amerigroup Washington** **Inc.** P.O. Box 61010 Virginia Beach, VA 23466 | **Community Health Plan of WA** P.O. Box 269002 piano, TX 75026 | **Coordinated Care** P.O. Box 4030 Farmington, MO 63640 | **Molina Healthcare of WA** P.O. Box 22612 Long Beach, CA 90801 | **United Healthcare** P.O. Box 29675 Hot Springs, AR 71903 |

for the purpose of; Verification of eligibility and submission of claims.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: 365 days after my file is closed.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Patient print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_

Signature of person signing form if not patient Describe authority to sign on behalf of patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization conforms with Federal regulations promulgated under 42 CFR Part 2; Subpart C. Records obtained as authorized by this consent form will be maintained in accordance with Federal Confidentiality Regulation (42 CFR, Part 2). This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT enough for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT TO RELEASE RECORDS CONTAINING SUBSTANCE ABUSE

INFORMATION 42 CFR Part 2 and HIPAA REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure. Your organization needs to verify this release and your processes are compliant with 42 CFR.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize **AXIUM RECOVERY SERVICES** to disclose the following with, **ABSULUTE DRUG TESTING, 1710 W. Mission Ave. Spokane WA 99201** This information will include the following:

**Lab/ UA**

for the purpose of; **UA-Results**

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. M118 Legal Action Center R 8/17

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. **Unless I revoke my consent earlier**, this consent will expire automatically as follows: **365** days after signing or **1** daysAfter Clients **File is Closed**.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. **I have been provided a copy of this form.**

Patient print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_

Signature of person signing form if not patient Describe authority to sign on behalf of patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_

This authorization conforms with Federal regulations promulgated under 42 CFR Part 2; Subpart C. Records obtained as authorized by this consent form will be maintained in accordance with Federal Confidentiality Regulation (42 CFR, Part 2). This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT enough for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Last Three arrest**

(Charge). (Year). (How much time served)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOC # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

CCO Name and Contact; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Three Treatment**

Year How long sober? **Not Including Incarceration time**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Highest Grade Completed?**

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

By signing below, I acknowledge I have read and agreed with Axium Recovery Services recommendation and given a copy of my signed agreements forms regarding.

* Consent to Treatment Agreement
* Clients Rights; WAC 246-341-0600; Grievance Contact Information.
* Medicaid participants 182-538-180 Rights and Protections.
* RCW [71.24.585](http://app.leg.wa.gov/RCW/default.aspx?cite=71.24.585) Opioid and substance use disorder treatment.
* Patient Notices (HIPPA policies)
* Confidentiality (limitations)
* Title 42 of the Code of Federal Regulations (CFR) Part 2
* Disclosure of Counselors/ Peer Support Specialist
* Unprofessional Conduct reporting contact information
* Patient Disclosure Information
* Social Media Policy – 24-hour Video Surveillance
* HIV, Bloodborne Pathogens, TB, & Covid -19 (Ed. Info/Resource)
* MCO ROI & UA Lab ROI and instructions / Directions
* Signed all third-party ROI (DOC, PO’s, Legal, Courts ext..) related to my continued care & Emergency Contact.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider One# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name** **of Patient**

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

**Signature of Patient**

Printed Name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Axium Recovery Services**

**901 E. 2nd Ave. Suite 201 Spokane, WA 99202**

**DRUG & ALCOHOL TESTING NOTIFICATION & INFORMATION**

**Client’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle In: \_\_\_**

**Client’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOC# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Swabbed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Observed: \_\_**X**\_\_\_

**12 PANEL SALIVA SWAB DRUG TEST:**

**1) MTD-**Methadone  **2) OPI-**Opiates **3) Oxy-** Oxycodone **4) PCP-** Phencyclidine  **5) THC-** Cannabis **6) AMP-** Amphetamine **7) BAR-** Barbiturate **8) BZO-** Benzodiazepines **9) COC-** Cocaine **10) MET-**Meth **11**)- **ALC**-Alcohol **12) BUP-** Buprenorphine

**Results:**

|  |
| --- |
|  |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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