New Patient Letter
Behavioral Health Services

Dear New Patient,

Thank you for choosing Aleutian Pribilof Islands Association, Inc. (APIA) for behavioral health services. We provide individual counseling, a wide variety of group therapy, substance use assessment, same day counseling for acute crisis, Community Reinforcement and Family Training (CRAFT)services and Awakuxtxin Intensive Outpatient Program (IOP) services in Anchorage, Atka, Nikolski, Saint George, and Unalaska/Dutch Harbor.

We hope our services will be provide a rewarding and valuable experience for you.

We require a registration packet for each patient:

Registration packets can be mailed, faxed, dropped off at our offices, or filled in by PDF and emailed or fill in the packet using jot form links below. Include ID, insurance & CIB card (if applicable). If you need assistance with the registration packet, or have questions, please let the front desk or your provider know during your first visit and they can assist you.

Registration
https://hipaa.jotform.com/APIA_BH/-client-intake-registration-form

ID and Insurance Card
https://hipaa.jotform.com/APIA_BH/id-and-insurance-card

Notice of Privacy Practices (NOPP)
https://hipaa.jotform.com/APIA_BH/APIAHIPPA

Telehealth Consent
https://hipaa.jotform.com/APIA_BH/apia-telehealth-consent

Release of Information (ROI)
https://hipaa.jotform.com/APIA_BH/apia-roi

OQ Screening Tool and/or GPRA Interview Form
This link may be sent by your provider (if needed)

Three Ways You Can Submit your Completed Registration Packet:

- Email registration@apiai.org
- Use jot form links above
- Drop off or mail to our APIA Behavioral Health offices

Telehealth Services:
We appreciate your patience as we provide telehealth services amongst the covid-19 crisis. Please review the APIA **telehealth consent form** if you are scheduled to receive telehealth services.

Insurance:
We recommend contacting your insurance directly for pre-authorization and cost.
APIA accepts IHS Benefits, Self-Pay, Medicaid, and Medicare. We are **not** considered "in-network" or contracted with any other insurance provider at this time.

Missed Appointments:
If you have an appointment that you cannot attend, please contact us immediately to cancel or reschedule. We monitor and manage the number of missed appointments in order to provide timely access for all patients and providers. After three missed intake appointments in a row, we are unable to schedule another appointment for six months. Established patients that frequently miss appointments "no show" either repeatedly or intermittently throughout the duration of their care, may receive a case review with their Behavioral Health Provider or Case Manager.

Escorts:
Our building is shared and our space is very limited. If you have an escort, please know that the escort will need to go with you to the Behavioral Health Department on the 2nd floor and wait in our waiting area. We have limited seating in our waiting area.

Our website:
More information on behavioral health services, our registration packet, and additional forms, such as our behavioral health service fee sheet, application for sliding scale/discount schedule program, and monthly payment plan, please visit the APIA Behavioral Health website at (https://www.apiai.org/services/health-care/behavioral-health/become-a-client/)

Contact:
If you have any questions, or need to reschedule or cancel an appointment, please email us at registration@apiai.org or contact us at 1-907-222-9764 or 1-844-375-2742.

APIA Behavioral Health
1131 E. International Airport Rd.,
Anchorage, Alaska, 99518

Crisis:
If you are in an immediate crisis, please call 911, Public Safety or Village Public Safety Officer (VPSO), and/or CARELINE (Alaska's Suicide & Someone-to-talk-to-line) 1-877-266-4357 or the APIA BH Crisis Line at 1-844-359-2743

To see if you qualify for Medicaid and/or Denali Kid Care, go to www.healthcare.gov

Aleutian Pribilof Islands Association Patient Registration

Anchorage (907) 276-2700 **Anchorage Behavioral Health** (907) 222-9764
Atka (907) 839-2232 **Nikolski** (907) 576-2204 **St. George** (907) 859-2254
Unalaska Primary Care (907) 581-2742 **Unalaska Behavioral Health** (907) 581-2751

Clear Form

Patient/Client Information

First Name: Middle: Last:

Date of Birth: SSN: Gender: ○Male ○Female ○Non-Binary ○Identify As:

Address: City: State & Zip:

Please check preferred number for contact:

○Home Phone: ○Cell Phone: ○Work Phone:

Can APIA leave a confidential voice message? ☐Yes ☐ No Ok to send appt reminders by text? ☐

Email: Internet Access? ○Yes ○No Ok to send email? ☐

(Emails are not encrypted)

Number of People that live with you: ___ Number of Children under 18 in Household:_____

Marital Status: (check one) Never Married-Single ○ Married ○ Cohabitating ○ Divorced ○Separated ○ Widowed ○

Reason you are seeking Behavioral Health services today:

Additional Parent/Guardian Information (Responsible Party) ☐Same as Patient

First Name: Middle: Last:

Address: City: State & Zip:

Please check preferred number for contact:

○Home Phone:_____ ○Cell Phone: _____ ○Work Phone:_____

Email: Date of Birth: Employer:

Tribal Affiliation/Ethnicity/ Language

Tribal/Native Corporation: Tribal Enrollment #

CIB: ☐Yes ☐ No

CIB Card in Medical Record? ☐Yes ☐No

Ethnicity: ☐Not Spanish/Hispanic/ Latino ☐ Spanish/Hispanic/ Latino

☐Unknown ☐Decline ☐Puerto Rican ☐Cuban ☐ Mexican American

Race (check all that apply): ☐Alaska Native: ☐American Indian: ☐Black/African American

☐Native Hawaiian ☐Pacific Islander ☐White ☐Asian ☐Other ☐Don't know ☐Decline

Primary Language if not English: ☐ Uuangam Tunuu ☐ Spanish ☐Russian ☐Tagalog ☐Other:_____

Translator/Interpreter Required: ○Yes ○No

Employment

Employment Status:

☐Active Military Duty ☐Full Time ☐Part Time ☐Disabled ☐Retired ☐Student

☐Subsistence or Seasonal ☐Unemployed looking for work ☐Unemployed ☐Homemaker

Employer:

Address: City:	State & Zip:

Primary Income Source: (check one)

◯Employment ◯Public Assistance/Welfare Pay ◯Alaska PFD ◯Parent's Income ◯Child Support
◯Social Security Disability (SSDI) ◯Social Security ◯Supplemental Security Inc (SSI)
◯Spouse/Significant Other's Income ◯Unemployment ◯Compensation ◯Self-Employment ◯Other_____

Education/Housing

Education: (check one)

◯High School Diploma ◯GED ◯Vocational Training ◯Special Ed ◯Bachelor's Degree (BA,BS)
◯Graduate Work (no degree) ◯Master's Degree Doctorate/Professional degree ◯Post-Secondary 2yrs(include AA degree)
◯No Schooling ◯Other_____

If K-11, What is the last grade you completed?_____ Currently attending grade school? ◯Yes ◯No

Living Arrangement: (check one)

◯Private Residence(House, Apt, Condo, Trailer, etc) ◯Someone Else's Private Residents(House, Apt, Condo Trailer, etc)
◯Private Residence with Supportive Services ◯Assisted Living Facility ◯Corrections/Detention Facility ◯Foster Care
◯Group Home ◯Halfway House ◯Homeless ◯Nursing Home ◯Shelter ◯Other_____

How do you feel about your living conditions?

◯Very Dissatisfied ◯Dissatisfied ◯Neither ◯Satisfied ◯Very Satisfied ◯Don't know

Health and Treatment Information

If Female, Are you pregnant? ◯Yes ◯No Unsure ◯

Are you an IV Drug User? ◯Yes ◯No

Date of last physical exam?___

Have you ever been in the hospital or residential treatment for substance abuse? ◯Yes ◯No

Have you been in the hospital in the last 6 months for medical problems caused by substance abuse? ◯Yes ◯No

How many inpatient mental health hospitalizations have you had? (If none, enter 0) ___

Legal History: Number of Arrests in the past 30 days (If none, enter "0") ___

Emergency Contact Information

Emergency Contact:	Relationship:
Address: City:	State & Zip:
Home Phone: Cell Phone:	Email :

Next of Kin ☐ Same as Emergency Contact	
Next of Kin:	Relationship:
Address:	State and Zip:
Home Phone:	Email:

Insurance Information (Please Provide your ID card)

Please list **ALL** members (people) in the household.
(spouse, child, foster child, grandparent, aunt, uncle, etc.)

Full Name	Relationship	Age

Total Annual Household Income Estimate:

This information will help us screen if you are eligible to apply for the APIA Sliding Fee/Discount Schedule.

○Under $15,000 ○$15,000-$30,000 ○$31,000 -$41,000 ○$42,000-$52,000 ○$53,000-$63,000

○$64,000-$74,000 ○$75,000-$85,000 ○$86,000-$96,000 ○$97,000-107,000 ○Above $108,000

Medicare: ○Yes ○No ○Primary ○Secondary Effective: Exp Date: #:

Medicaid: ○Yes ○No ○Primary ○Secondary Effective: Exp Date: #:

Denali Kid: ○Yes ○No ○Primary ○Secondary Effective: Exp Date: #:

Private Insurance: ○Yes ○No (please provide your ID card)	Insurance Company:

Policy Holder:	Policy #:	Group #:
Other Insurance:	Policy #:	Group #:
Veteran: ○Yes ○No	VA Benefits: ○Yes ○No	Service Branch:

Service Entry Date:	Service Exit Date:	Vietnam Service Indicated? ○Yes ○No

☐ I DO NOT have any other insurance coverage from any other source other than the above mentioned

Self Pay/Guarantor:		Relationship:
DOB:	Phone:	Address:
City:	State/ Zip:	Effective Date:

Referral Information

☐Self-Referral ☐Family/Relative ☐Friend ☐Behavioral Health Provider ☐ Medical Provider ☐Court

☐Clergy ☐School ☐Social Services ☐SCF ☐OCS ☐Other:

Medical Referral: Would you like to be contacted by the Medical RN? ◯Yes ◯ No
Or a referral for a physical exam? ◯Yes ◯No

Advance Care Planning

I have an Advance Health Care Directive, also known as a living will, Durable Power of Attorney, POLST or Comfort One:
◯Yes ◯No ◯Pt Less than 18 yrs. ◯Unable to Access: Reason_____

I have a Psychiatric Advance Directive: ◯Yes ◯No ◯Pt Less than 18 yrs. ◯Unable to Access: Reason_____

If yes, is your Advance Health Care Directive on file? ◯Yes ◯No Last date reviewed:_____

If no, would you like information regarding Advance Health Care Directives? ◯Yes ◯No

Consent

Consent: I hereby certify that all information provided is true and correct to the best of my knowledge and I give my consent for APIA to administer–assessments and/or–treatments to perform behavioral health or medical services. APIA operates as an integrated health system and may refer patients as necessary.

I _____(printed name) authorize APIA Behavioral Health Providers to disclose general mental health, housing, drug or alcohol use information to APIA staff for the purpose of program evaluation and grant reporting. I understand I may be contacted to complete a questionnaire over the telephone or by email. I understand that I may revoke this authorization at any time preventing future use. Unless I revoke my consent earlier, this consent will expire automatically one year from active services at APIA.

Assignment of Medical Insurance Benefits: I hereby agree to full responsibility for all expenses incurred by or on account of this patient and assign to APIA, Inc. any and all insurance benefits due to me to the full extent of my financial obligation and said providers. This is certification and authorization is valid until otherwise revoking in writing.

I consent to full financial responsibility for services rendered at APIA, Inc.

Signed: _____ Date: _____

Guardian: _____ Date: _____

Release of Confidential Information (ROI) on file? ◯Yes ◯No

Notice of Privacy Practices& Patient Rights and Responsibilities

Anchorage-Atka-Nikolski-Saint George-Unalaska

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ALEUTIAN PRIBILOF ISLANDS ASSOCIATION (APIA), AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care.

Our Duties

We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect. We will also notify you if a breach occurs that may have compromised the privacy or security of your information.

How We May Use and Disclose Health Information About You

We will not use or disclose your health information without your authorization, except in the following situations:

Treatment: We may use and disclose your health information while providing, coordinating or managing your health care. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We may also provide other healthcare providers with your information to assist him or her in treating you.

Payment: We may use and disclose your health information to obtain or provide compensation or reimbursement for providing your health care. For example, we may send a bill to you, your employer (if services were ordered by your employer) or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As another example, we may disclose information about you to your health plan so that the health plan may determine your eligibility for payment for certain benefits.

Health Care Operations: We may use and disclose your health information to deal with certain administrative aspects of your health care, and to manage our business more efficiently. For example, members of our staff may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. We may disclose your health information to our business associate so they can perform the job we have asked them to do, such as storing test results or processing billing information. However, we require the business associate to take precautions to protect your health information.

Notification of Family: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

Court Proceeding: We may disclose your health information in response to requests made during judicial and administrative proceedings, such as court orders or subpoenas.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Other Uses: We may also use and disclose your personal health information for the following purposes:

- To contact you to remind you of an appointment;
- To describe or recommend treatment alternatives to you; or
- To furnish information about health-related benefits and services that may be of interest to you. On rare occasions, we may disclose information for the following purposes: Food and Drug Administration (FDA), Public Health, Reporting Abuse, Neglect or Domestic Violence, Health Oversight, Law Enforcement, Threats to Public Health or Safety, and Specialized Government Functions (military, national security).
- For fundraising, however, you can tell us not to contact you for this purpose.

Prohibition on Other Uses or Disclosures

We may not make any other use or disclosure of your personal health information without your written authorization. Once given, you may revoke the authorization by writing to the contact person listed below. Understandably, we are unable to take back any disclosure we have already made with your permission.

Special Rules About the Confidentiality of Your Alcohol and Drug Abuse Information

If you are receiving alcohol or drug abuse services from a recognized APIA substance abuse program, information that would identify you as a person seeking help for a substance abuse problem is protected under a federal law known as "Confidentiality of Alcohol and Drug Abuse Patient Records." Under certain circumstances these regulations will provide your health information with additional privacy protections beyond those that have already been described. However, not all records for these programs are necessarily provided extra protection as substance abuse records if they do not identify you as a person seeking help for substance abuse.

For more information about the specific ways in which these protections apply, see 42 U.S.C. 290dd-3, 42 U.S.C. 290 ee-3 and 42 CFR Part 2.

In general, any information identifying you as addressing a substance abuse problem cannot be shared outside of the APIA substance abuse treatment programs without your specific written consent. Exceptions to this rule include court orders to release your health information, the provision of your health information to medical personnel in an emergency, and for audits or program evaluations. Before your substance abuse health related information can be released to family, friends, law enforcement, judicial and corrections personnel, public health authorities, other providers of medical services, we are required to obtain your written authorization to do so, unless an exception to the legal protection applies. This authorization can be revoked orally, but we are unable to take back any disclosure we have already made with your permission.
In those instances, where you did authorize us to release your substance abuse related health information, the authorization will always be accompanied by a notice prohibiting the individual or agency/organization receiving your health information from re-releasing it unless permitted under applicable federal law.
To facilitate communication with other organizations that provide services such as legal advice, laboratory analyses or other services to APIA's substance abuse programs and patients, we may establish a confidentiality agreement with those organizations. Under this agreement, we may share, without your consent, information about the substance abuse care that you are receiving with the other organization. However, the confidentiality agreement requires that the other organization abide by the same rules described in this Notice to keep information about your substance abuse problem and the care you are receiving confidential.

Violation of these provisions is a federal crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. If you have questions about whether these additional protections apply to the treatment you receive, contact the Compliance Officer (Privacy Officer Delegate) at the APIA address listed.
To the extent anything in this Notice conflicts with the protections described in this special section regarding substance abuse treatment, the portion of the Notice providing you with greater protection will apply.

Individual Rights
You have many rights concerning the confidentiality of your health information. You have the right:
To request restrictions on the health information we may use and disclose for treatment, payment, and health care operations. We are not required to agree to these requests, unless your request is to restrict information sent to your insurance company regarding treatment you have paid for entirely out-of-pocket. To request restrictions, please send a written request to the APIA address listed.
To receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. To make such a request, you must write to us at the APIA address listed, and tell us how or where you wish to be contacted.
To inspect or copy your health information. You must submit your request in writing to the APIA address listed. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. If your records are held in electronic form, you have the right to request a copy in electronic form. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
To receive a copy of this notice in paper format, please contact APIA at the number or address listed.
To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if:

- The information was not created by us, unless the person that created the information is no longer available to make the amendment,
- The information is not part of the health information kept by or for us,
- Is not part of the information you would be permitted to inspect or copy, or
- Is accurate and complete

To receive an accounting of disclosures of your health information. You must submit a request in writing to the address below. Not all health information is subject to this request. Your request must state a time period, no longer than six years and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically). The first accounting you request within a 12-month period is free. For additional accountings, we may charge you the cost of providing the accounting. We will notify you of this cost and you may choose to withdraw or modify your request before charges are incurred.
All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed below.

Complaints
If you believe that your privacy rights have been violated, a complaint may be made to our Compliance Officer or Privacy Officer at 1-800-478-2742 or at the APIA address listed. We request the use of our Consumer Concern form for filing complaints. You may also submit a complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Contact Person
Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Compliance Officer, Health Director
1131 East International Airport Road
Anchorage, Alaska, 99518-1408
1-800-478-2742

Changes to This Notice
We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.
Notice Effective Date: January 10, 2011.
Revised: December 6, 2019

Patient Rights and Responsibilities

APIA Behavioral Health and Primary Care uphold that all patients have the following

RIGHTS:
1.To be treated with dignity and respect, regardless of one's race, creed, religion, disability or sexual preference;
2.To help develop a plan of care for services that meet one's specific mental health, substance use need(s);
3.To participate in decisions regarding one's behavioral health care;
4.To refuse treatment and change one's mind at any time; **IMPORTANT** Patient may be treated without consent only in cases of an emergency and in the professional opinion of one's provider that failure to act immediately would jeopardize the client's health.
5.To request and receive a discharge plan recommending specific self-help procedures and other steps that benefit one's mental health and well-being;
6.To know the name and titles of all personnel directly involved in one's treatment and to consult with treatment team members;
7.To have all information related to one's care protected by confidentiality;
8.To refuse participation or interviews related to research purposes;
9.To appeal specific treatment decisions to higher authorities for review;
10.To participate, as far as is practical and desirable, in treatment within the clinic and community;
11.To be informed of one's rights to leave the treatment program; and
12.To not be subjected to physical abuse, corporal punishment or other forms of abuse and retaliation by staff.

The patient also has a number of RESPONSIBILITIES:
1.Patient has the responsibility to participate actively and honestly in treatment. In many cases, particularly when the patient is a child or adolescent, effective treatment requires active involvement and participation of parents or other family members.
2.Patient has the responsibility to keep scheduled appointments or give 24-hour notice of cancellation if patient will be unable to keep an appointment.
3.Patient has the responsibility to treat other patients and APIA personnel with dignity and respect,
realizing that any act of aggression, breaching another patient's confidentiality, or any other inappropriate behavior will be grounds for involuntary termination from the program.
4.Patient is responsible for asking questions about any policy, procedure, or service which they do not understand or with which they do not agree.
5.Patient has the responsibility to honor their financial contract by paying for the services at the time services are provided, unless other financial arrangements have been made in writing.
6.Patient is responsible for providing all information necessary for billing health insurance or other third-party insurance, including change in address, income, insurance information, etc.
7.Patient has the responsibility to inform one's counselor of expected and emergency absences. The counselor will determine if an absence is excusable. All individual and group services begin on time and lateness may be considered an unexcused absence. Two unexcused absences will be grounds for involuntary termination from current services.
8.IF PATIENT PARTICIPATES IN GROUP COUNSELING: Patient is responsible for, and agrees to pay for, all group sessions attended. Patient may be required to make up sessions to successfully complete a program
9.Patient is responsible for their own progress and understands it is the program's responsibility to assist patients in realizing their goals.

Contact Us

Aleutian Pribilof Islands Association, Inc.
1131 E. International Airport Rd
Anchorage, AK 99518
Visit us on the Web: www.apiai.org
Scheduling: 907-222-9764 Main: 907-276-2700
1-800-478-2742 (toll free) Fax: 907-279-4351
Health Fax (Confidential): 907-222-4279
Behavioral Health Scheduling 1-844-375-2742 (toll free)

Aleutian Pribilof Islands Association, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

By signature below, I acknowledge that I have received Aleutian Pribilof Islands Association, Inc. Privacy Practices and Patient Rights and Responsibilities.

❒ I retained a paper copy for my records.

❒ I decline a paper copy for my records.

_____ _____

Printed Name **Date**

_____

Signature

This acknowledgement page will be kept in the client's record.

If acknowledgment could not be obtained from the client, the reasons **must** be documented below.

Office Use Only:

❒ Individual refused to sign

❒ Emergency Situation

❒ Other (Please specify) _____

Consent for Release of Confidential Information

Serving: Anchorage, Atka, Nikolski, Saint George, Unalaska

Name: _____ **DOB:**_____

Address: _____
Street or PO Box City State Zip Code

Telephone: _____**Parent/Legal Guardian:** _____

I grant permission for: **Aleutian Pribilof Islands Association, Inc., Behavioral Health**
1131 E. International Airport Rd., Anchorage, AK 99518
Main: 907-276-2700 Fax: 907-222-4279

☐ Atka Health Clinic ☐ Anchorage Behavioral Health ☐ Nikolski Health Center ☐ Saint George Health Center
☐ Oonalaska Wellness Center (primary care) ☐ Oonalaska Wellness Center (behavioral health)

To (check all that apply):

	☐ Release Information to	☐ Obtain information from
	☐ Verbally	☐ In writing and/or electronically

Name: _____**Agency:**_____

Address: _____ **Telephone:** _____
Street or PO Box City State Zip

Regarding the following information (**CLIENT INITIAL** all that apply):

	Assessment, including diagnosis & treatment recommendations (Sub Use Only, MH Only, Integrated)		Psychiatric Evaluations or Psychological Assessments
	Admission Summary		Treatment Status or progress in treatment
	Results of Urinalysis and/or alcohol breathalyzer		Discharge Date and Summary
	Attendance / Compliance		BH Medication Needs
	Treatment Plan		Other (please specify):

For the following purposes (**CHECK** all that apply):

☐	Referral/Treatment Placement follow-up	☐	Coordination of services or care
☐	Provide referral information	☐	Other (please specify):
☐	Verify participation in treatment	☐	Other (please specify):

I understand that my alcohol and/or drug treatment records are protected under Federal laws governing the confidentiality of substance use disorder records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Treatment and benefits will not be contingent on signing this ROI, except to the extent that an ROI is necessary under 42 CFR Part 2 for payment purposes. **I also understand that I may revoke this consent orally, pursuant to 42 C.F.R. Part 2, or in writing at any time** except to the extent that action has been taken in reliance on it (any information that has already been released cannot be recalled). This consent will expire one year from date signed or on:_____ whichever is earlier.

_____I have received / declined a copy of this form.

Client or Legal Guardian Signature: _____Date: _____

Witness Signature: _____Date: _____

****

☐ **(Check if Substance Use Information is Included)**

To the Recipient of Confidential Information

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 further disclosure of this information unless further disclosure is expressly permitted by 42 CFR 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 the information to criminally investigate or prosecute any alcohol or drug patient.

APIA

With Spirit and Strength

APIA Behavioral Health Services

Telehealth services are provided for easy access to our behavioral health services. Telehealth and video therapy sessions allow you to get the care you need-when, where and how you need it. Telehealth service is not required and is only used if it is a good fit with the provider and patient.

If you are concerned about covid-19, or just want the convenience of staying at home, we can provide telehealth care to patients in **Atka, Nikolski, Saint George, Unalaska/Dutch Harbor and Anchorage.**

To access telehealth services:

A quiet, private location is the most beneficial. APIA telehealth services use ZOOM to connect patients using a device, such as a smart phone, tablet or computer with video. We use ZOOM through CERNER, an electronic secure platform.

Prior to the first appointment, the APIA front desk staff will contact the patient by email or phone with directions on how to use ZOOM telehealth services for the first appointment. A link will be sent that is unique to the patient and can be used at each appointment.

A valid email address is needed for the purpose of scheduling and generating an appointment with a device. Emails are not a secure form of transmitting information and should be used just for the purposes of scheduling and not to share sensitive information with your provider.

Internet service (usage) fees are not covered by insurance or APIA.

Telehealth services may also be provided through a landline telephone.

Telehealth services are subject to the following:

- Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider decides that telehealth is not a good fit for you or your situation, the provider may choose to end the session and request an in-person session at a later date.

- Telehealth services will be scheduled in advance.

- Telehealth services provided through a device should be accessed through a safe and secure connection. Be sure to use a device that is in a confidential or private area and always fully close all online counseling sessions when they are complete.

- Telehealth services may also include ways to talk with your provider, such as posting of notes or chat logs during the session. This information may be printed by your provider, and if so, it will be treated as confidential.

• If telehealth services cannot be done due to technical issues, you should immediately contact your provider by telephone or email them to schedule a new session.

• Telehealth services are not appropriate for emergency situations.

• Some videoconferencing services may retain certain personal information for its users. This could include user contacts and addresses, and other personal information you provide to the service. You should review the privacy policy for the internet service provider if you have any questions about the confidentiality of such information.

Telehealth Consent

- Using telehealth services is entirely voluntary and will not impact the quality of care you receive from the organization should you decide not to use these services.

  Aleutian Pribilof Islands Association, Inc. (APIA) is not liable for any claims and/or damages arising from following:

  i. Interruption in the ability to conduct telehealth services due to technical difficulties, technical maintenance, or system failure.

  ii. Access by friends, family members or other third parties who may enter the room on the client side during telehealth sessions.

  iii. Breaches of privacy and security due to the fault of the third-party videoconferencing provider (such as Zoom, Skype, Vidyo, etc.).

- By signing below, you consent to the conditions described herein and agree to adhere to the policies set forth above, as well as any other guidelines that the Organization may impose for using electronic communications.

Date: _____

I would like my telehealth invite to be sent to:_____
(provide email address above)

Patient Name (Type or Print):_____

I have access to a device, such as a smart phone, tablet or computer with a camera in a secure location.
___Yes ___No

Patient Signature:_____