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

General Information:

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

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

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

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

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

Revised: 4/6/2019

Your Rights

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

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

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

Jett Morgan Treatment Services LLC's Duties

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

Complaints and Reporting Violations

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

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

Contact

For further information, contact Michelle Jett, Director of Operation/ Owner at 907-677-7709.

Effective Date: 3/28/2011

Acknowledgement:

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

______________________________________ ________________
Printed Name Date

____
Signature

Informed Consent for Screening, Assessment and Referral

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

SECTION I: GENERAL (PLEASE INITIAL ALL OF THE FOLLOWING)

____ I agree to actively participate in the screening, assessment and referral processes. I understand that it is my responsibility to follow up with all recommendations and referrals.

____ I understand that my consent for alcohol and other drug treatment services is voluntary and may be withdrawn at any time.

____ I further understand that any changes in my assessment and/or treatment recommendations will be discussed with me prior to such changes becoming effective.

____ Subject to ongoing assessment and evaluation of my treatment progress, I may expect changes in the level and duration of services while I am enrolled. Further, I may expect these changes to be discussed by the treatment team and any modifications will be in the best interest of my treatment.

____ I acknowledge and understand that no promise or guarantees have been made to me regardless of the outcome of my treatment referral by Jett Morgan Treatment Services, LLC and do hereby absolve Jett Morgan Treatment Services, LLC from liability in the event my treatment referral is unsuccessful.

____ I hereby authorize Jett Morgan Treatment Services, LLC to contact me by mail, telephone, email or in person after my screening, assessment, or referral as follow-up is an integral part of my overall treatment.

SECTION II: ATTENDANCE & TREATMENT CHARGES

____ I agree to be on time for all scheduled appointments. I understand that if I am late, I may be rescheduled or returned to my referral source.

____ I agree to contact the agency 24 hours prior to missing a scheduled appointment to reschedule. I understand that if I fail to provide 24-hour notice to cancel or reschedule my appointment I will be charged a late cancellation fee.

____ I acknowledge that all fees for services are due to and payable at the time of the service unless other arrangements have been made for me.

SECTION III: EXPLANATION OF RIGHTS

1. **Rights of Confidentiality**

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

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

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

2. **Bill of Rights**

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

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

3. **Civil Rights**

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

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

SECTION IV: CONFIDENTIALITY AND ANONYMITY AGREEMENT

It is essential that all persons visiting, attending, incarcerated and or residing at Heart of Gold Ministries INTL understand the importance of safeguarding the confidentiality and anonymity of those individuals who are seen on these premises or who are receiving any type of service.

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

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

Those at least twelve (12) years of age and above must sign this form. Persons accompanying children under the age of twelve years must explain to them the importance of respecting the complete privacy of those at Heart of Gold Ministries INTL as well as the events or activities occurring therein.

Client Statement:

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

_______________________________________ _______________________

Signature of Client Date

Witness Statement

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

_______________________________________ _______________________

Signature of Witness: Date:

EMERGENCY CONTACT INFORMATION

Client Name:_______________________________________ Client Number:_________________

Address:____

Home Phone:_________________ Cell Phone:_________________ Mess Phone:_______________

Allergies:____

Medical Conditions:____

Medications:____

____

Primary Emergency Contact (required)

First & Last Name:____________________________________ Relationship:___________________

Address:____

Home Phone:_________________ Cell Phone:_________________ Mess Phone:_______________

Secondary Emergency Contact (required)

First & Last Name:____________________________________ Relationship:___________________

Address:____

Home Phone:_________________ Cell Phone:_________________ Mess Phone:_______________

I authorize Hear of Gold Ministries INTL to provide the information contained on this form to emergency medical providers in case of a medical emergency.

Client Signature____Date___________________

Staff Signature____Date___________________

Last Name:		First Name:		Middle:
Please list any previous legal names:		Social Security Number (required):		
Birthdate:	Age:	Sex:	Marital Status (check one)	
		☐Male	☐Single ☐Married ☐Separated	
		☐Female	☐Cohabiting ☐ Divorced ☐Widowed	
Cell Phone Number:	May we leave voice message?			
	☐ Yes ☐ No			
Home Phone Number:		May we leave voice message?		
		☐ Yes ☐ No		
Work Phone Number:		May we leave voice message?		
		☐ Yes ☐ No		
Email Address:		May we contact you at email address?		
		☐ Yes ☐ No		
Street Address		City, State and Zip Code address?		
Mailing Address		City, State and Zip Code address?		
Employer:				
Have you ever served in the military? ☐ **Yes** ☐ **No**				
Vietnam Era Veteran: combat or non-combat? Gulf War Veteran: Combat Iraq War Veteran; Combat Afghan War Veteran; Combat		On Active Duty; Combat or No Combat? Reserves or National Guard: Combat or Non-Combat Retired from Military; Combat or Non-Combat? Veteran; Other Eras?		

Describe Presenting Problem (please provide a short summary of what led you here)?

Date:______________________________

Referred By: *Check ALL that apply*

☐ Attorney	☐ Employer	☐ Office of Children Services
☐ Court-ASAP	☐ Family/friend	☐ Probation/Parole: State
☐ Court-Other	☐ Halfway House	☐ Probation/Parole: Federal
☐ Mental health	☐ Hospital: _______	☐ Self
☐ Juvenile Justice	☐ Medical provider	☐ Other: ______________

Race and Ethnicity: *Check ALL that apply*

	Alaskan Native:	**Hispanic or Latino:**
☐ Asian	☐ Aleut	☐ Cuban
☐ Black/African American	☐ Athabascan	☐ Mexican
☐ Caucasian	☐ Inupiat	☐ Puerto Rican
☐ Pacific Islander	☐ Yupik:	☐ South American
☐ American Indian	☐ Other:______________	☐ Central American
☐ Other:________________		

Please Complete!

Citizenship:______________ Place of Birth:_______________________

Religious Preference:_________________

Sexual Orientation: Straight, Gay, Lesbian, Bisexual or Other: ______________

Special/Priority Needs: *Check ALL that apply*

☐ None
☐ Developmentally Disabled
☐ Major Difficulty in Moving
☐ Moderate/Severe Medical
☐ Problems FAS/FAE/FASD
☐ Severe Hearing
☐ Loss/Deaf Traumatic
☐ Brain Injury Visual
☐ Impairment/Blind

- Are you currently pregnant? Yes No
- Will you require special assistance while attending treatment? Yes No
- Do you have Insurance? ___________

Services Needed?: *Check ALL that apply*

☐ Alcohol Drug Information School (ADIS)
☐ Continuing Care
☐ Anger Management
☐ Assessment
☐ Integrated Assessment
☐ Mental Health Referral
☐ Treatment--Outpatient
☐ Treatment--Intensive Outpatient
☐ Treatment--Residential
☐ Other: _________

- Do you have a history of sucidial ideation or attempts, if so, when what the last time? _____________

Education:

☐ **If K-11, how many years?** _______
☐ GED ☐ High School Diploma
☐ Vocational training
☐ Post-Secondary (no degree)
☐ AA degree
☐ Bachelor's degree
☐ Master's degree/ Doctoral degree
**Were you enrolled in Special Ed or had an IEP?
☐Yes ☐No

Language:

*Is English your first language?☐ Yes ☐ No
*If no, what is your first language? ___________
*How would you rate your ability to understand English?
☐Excellent ☐ Good☐ Fair☐Poor
*How would you rate your ability to write in English?☐Excellent ☐Good ☐ Fair ☐Poor

*Will you require help writing English?☐Yes ☐No

Substance Use Information: Required**

Substance of Choice:

Ever IV drugs?☐Yes ☐No
Date of last IV use:_____________

Late Cancellation Policy

- All scheduled appointments are subject to a no show/ late cancellation fee of **$25.00** if you fail to cancel or reschedule your appointment 24 hours prior to the scheduled appointment.

- You are required to pay late cancellation fees at your next appointment. All fees are expected at the time services are rendered and you will not be seen or admitted into group until payment is received.

Refund Policy

- Jett Morgan Treatment Services, LLC, does not provide refunds on any monies paid, **NO EXCEPTIONS.**
  - This includes prepaid assessments and any other sessions.
  - It is your responsibility to follow through with all appointments. You may apply unused credits towards other or future services.
  - If you have any questions or concerns, please do not hesitate to contact Stephanie Claiborne @Heart of Gold Ministries INTL.

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

____________________________________ __________
Print Name and Signature Date

____________________________________ __________
Staff Signature Date