

Welcome to Cognitive Restructuring, LLC!

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

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

Your clinician will be with you shortly.

Thank you very much!

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

Client Support Sheet

Client Name: _____ Phone: () _____ - _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____ Age: ____ Gender: ____

Date Completed: _____ Employer/School: _____

Emergency Contact Name: _____ Phone: () _____ - _____ Relationship: _____

Emergency Contact Name: _____ Phone: () _____ - _____ Relationship: _____

Legal Guardian/POA Name (If applicable): _____ Phone: () _____ - _____

Outside Agency Contacts:

ROI: _____ Refused _____ None _____

Counselor/Therapist: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Case Manager: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Peer Support Specialist: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Psychiatrist/Psychologist: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Primary Care Physician: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Probation Officer: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Family Member: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Other Medical Provider: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Other: _____ Phone: () _____ - _____ Email: _____ Y N Date: Faxed: _____ ☐ ☐ ☐

Primary Insurance Company _____ Member ID # _____ Group# _____

Insurance Company _____ Member ID # _____ Group# _____

Reason(s) for starting Services: _____

Comments: _____

Cognitive Restructuring, LLC

Protections under HIPAA and Omnibus Rule 9-23-2013

Name: _____ Date: _____

Information Line: 1-800-368-1019

Access to Medical Records

Clients may have access to medical records to copy and amend or request amendments

Access will be provided within 30 days of client request for their file review

Is permissible to charge client for copying and sending costs

Request an Accounting of Record

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

Privacy

Clients signs or initial or otherwise acknowledges written document of how their health information is to be used

If client does not agree they can disagree to any of the reasons

Limit Use of Medical Information

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

Prohibition on Marketing

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

State Law Strength

Reporting based on state law does not violate HIPAA regulations

Confidential Communication

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

File Complaints

On-line at <http://www.hhs.gov/ocr/hipaa> or by calling (866) 627-7748

Complaints can be filed with provider or with Office for Civil Rights, above

Training

Entities must train personnel in privacy and designate a person responsible to ensure procedures are followed

Disciplinary action by the entity must be taken when personnel fails to follow procedures

Public Responsibilities

Entities may continue to disclose for public responsibility based on judgment and entity policy

Identification of a body of a deceased person

Cause of death

Communicable disease reporting or to avert serious threat to health or safety

Limited data or has been approved by Institutional Review Board or privacy board

Oversight of health care system

Judicial and administrative proceedings

When required by military; command authorities if client in military

For persons in police custody to protect safety and security of correctional institution

Limited law enforcement activities

Workman's Compensation information needed to complete claim process

To business associates within the entity structure

Injury or disability

Abuse or neglect

Provide information about a crime

Activities related to national security

To locate or apprehend a suspect, fugitive, or missing person

Report a crime on the premises and if entity is responding to an emergency report crime information

Equivalent Requirement for Government

Rules apply to private and public entities

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

Client/Parent/Guardian Signature

Date

Cognitive Restructuring, LLC

Provider Choice List

(Circle choice of provider)

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

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

Client/Guardian Signature

Date

Cognitive Restructuring, LLC

Client Rights and Responsibilities

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

Client Responsibilities are on the next page.

Cognitive Restructuring, LLC

Client Rights and Responsibilities

The agency asks that every Client is aware of the following responsibilities:

- You are responsible for providing the agency and the care providers with information needed to provide quality care.
- You are responsible for understanding your health problems to the best of your ability. You are responsible for participating in treatment and recovery goals both you and your care providers agree on.
- You are responsible for following these treatment and recovery plans to the best of your ability. You must let providers know if changes are needed.
- You are responsible for keeping, changing, or cancelling appointments instead of not showing up.
- You are responsible to provide accurate financial information prior to receiving services received and notify the agency of any changes.
- You are responsible to pay any and all debt incurred through services received within thirty (30) days of being notified of the balance of said debt, unless prior payment arrangements have been made with an agency representative. Unpaid balances over ninety (90) days will be referred to a collection agency.

Client/Parent/Guardian Signature

Date

Cognitive Restructuring, LLC

Information Disclosure and Consent

Date: _____

Client Name: _____

Parent/Guardian Name: _____

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

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

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

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

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

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

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

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

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

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

Prohibition of Re-Disclosure Statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by rules (42 C.F.R. Part 2.) A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse of patient. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal Regulations).

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

Cognitive Restructuring, LLC

Information Disclosure and Consent

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

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

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

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

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

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

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

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

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

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

Special Commitments and Instructions for Groups:

Client agrees and commits to attend groups as collaboratively agreed upon.

Client agrees to attend all groups and individual sessions sober.

Client agrees to notify Cognitive Restructuring, LLC and other overseeing professionals if groups are missed.

Client agrees to laws of confidentiality and failure to abide by confidentiality regulations will constitute dismissal from group.

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

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

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

Cognitive Restructuring, LLC

Information Disclosure and Consent

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

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

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

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

Selection of Service Choice "x"	Services Offered	Description and Goal of Service
	Anger Management	Helping the individual in learning techniques of emotional regulation.
	Case Management	Assisting individuals to access appropriate services.
	Drug & Alcohol Assessment	Clinician performs to determine level of care.
	Drug & Alcohol Outpatient, Intensive Outpatient, High Intensive IOP, PHP	Helping individuals work toward sobriety and high functionality in all six dimensions of treatment and to enhance quality of life.
	Drug Testing	On-site drug testing for individuals in Drug & Alcohol treatment.
	DUI Education	Twelve-hour education using MRT Driving the Right Way, CBT, Motivational interviewing and safety planning.
	Foundations of Recovery	Half-way house for men in SUD recovery.
	Individual Psychotherapy	Helping individuals in their search for understanding and resolution.
	Mental Health Assessment	Clinician performs to determine level of care.
	Parenting Support	Helping caregivers learn techniques of attachment and interactions.
	Peer Support Services	Community based peer to help you work towards mental health wellness goals.
	Recovery Coaching Services	Community based peer to help you work towards SUD recovery goals.
	Groups: Anxiety, DBT, MRT, RPG I & II, Seeking Safety, SMART, TFAC and Women in Recovery	One-hour groups. Clinician will recommend in level of care determination.

ALL SERVICES IF INSURANCE/SELF-PAY ARE DUE AT TIME OF SERVICE

Service	Payment Schedule (Costs are subject to change)
Anger Management	\$160.00 for eight (8) sessions.
Case Management	\$55.00 session
CDA	\$150.00

Cognitive Restructuring, LLC

Drug & Alcohol Assessment	\$180.00
Drug & Alcohol Outpatient, Intensive Outpatient, High Intensive IOP, PHP	\$30.00 per group. \$50.00 for ½ hour individual session. \$100.00 for 1 hour individual session.
Drug Testing	\$20.00 per test.
DUI Assessment	Not available – referred out
DUI Education	\$30.00 per group \$50.00 for ½ hour (individual)
Foundations of Recovery (Safe and Sober House)	\$450.00 self-pay \$100.00 Non-Medicaid funding source \$100.00 Waived if in SUD PHP for Non-Medicaid funding source
GAIN Assessment	\$180.00
Individual Psychotherapy	\$55.00 for ½ hour individual. \$110.00 for 1 hour individual.
Mental Health Intake	\$110.00 for self-pay.
Parenting Support	\$30.00 per session for twelve (12) sessions.
Peer Support Services	\$50.00 per session.
Recovery Coaching Services	\$50.00 per session.
SUD Intake	\$110.00 per session.
Groups: Anxiety, DBT, MRT, RPG I & II, Seeking Safety, SMART, TFAC and Women in Recovery	\$30.00 per group.

Please indicate the following statements that pertain to you:

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

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

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

Client/Guardian Signature

Date

Personnel Signature

Date

Cognitive Restructuring, LLC

Client Email/Texting Informed Consent Form

Page 1 of 2

1. Risk of using email/texting

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

- a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- d. Employers and on-line services have a right to inspect emails sent through their company systems.
- e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- f. Email and texts can be used as evidence in court.
- g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

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

- a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- c. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
- d. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
- e. Provider is not liable for breaches of confidentiality caused by the client or any third party.
- g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Cognitive Restructuring, LLC
Client Email/Texting Informed Consent Form

Page 2 of 2

3. Client Acknowledgement and Agreement

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

Please mark only 1 choice below by initialing:

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

Email: _____

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

Phone: _____

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

Client Name: _____

Client Signature: _____

Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

Cognitive Restructuring, LLC

Employee Signature: _____

Date: _____

Cognitive Restructuring, LLC

TeleHealth Informed Consent Form

Page 1 of 2

1. Risk of using electronic devices for services:

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

- a. Information can be circulated, forwarded, stored electronically and broadcast to unintended recipients.
- b. Senders can easily misdial or send the information to an undesired recipient.
- c. Electronic devices may create backup information even after the sender and/or the recipient has deleted his or her copy.
- d. Electronic devices may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

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

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

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

Cognitive Restructuring, LLC

TeleHealth Informed Consent Form

Page 2 of 2

3. Client Acknowledgement and Agreement

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

Please mark only 1 choice below by initialing:

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

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

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Cognitive Restructuring, LLC

Employee Signature: _____ Date: _____

Cognitive Restructuring, LLC

Consent to Release and Exchange of Information

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

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

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

_____, to _____
(Name of Client) (Name of Agency or Individual – include relationship)

(Contact Information) Street Address City State Zip)

(Phone) _____ (Company Fax) _____

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

The records requested are for the following services:

_____ <input type="checkbox"/> Substance/Alcohol Abuse Services	_____ <input type="checkbox"/> Mental Health Services
_____ <input type="checkbox"/> Case Management	_____ <input type="checkbox"/> HIV/AIDs related information
_____ <input type="checkbox"/> RSS Services(Other)	_____ <input type="checkbox"/> Legal Services

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

Specific Information Requested:

_____ <input type="checkbox"/> GAIN Assessment	_____ <input type="checkbox"/> Admission/Discharge Summary
_____ <input type="checkbox"/> Comprehensive Diagnostic Assessment	_____ <input type="checkbox"/> Court Related Information
_____ <input type="checkbox"/> Social/Medical History	_____ <input type="checkbox"/> Case Management Plans/Progress
_____ <input type="checkbox"/> History & Physical Exam	_____ <input type="checkbox"/> Treatment Plans
_____ <input type="checkbox"/> Laboratory Data(Drug Testing)	_____ <input type="checkbox"/> Exchange Information
_____ <input type="checkbox"/> Probation/Parole Progress Reports	
_____ <input type="checkbox"/> Medication Records	_____ <input type="checkbox"/> Other: _____

Cognitive Restructuring, LLC

Consent to Release and Exchange of Information

The purpose of the disclosure authorized herein is to: _____
(Purpose of disclosure, as specific as possible)

I understand the my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed with my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any events this consent expires automatically 365 days post-discharge from the treatment program.

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

Client Signature

Date

Parent/Guardian Signature

Date

Cognitive Restructuring Employee Signature

Date

BPA Clients Only
Idaho Substance Abuse Treatment and Recovering Support Services

Consent for Release of Information

I, _____, am requesting substance abuse services from Idaho's publicly funded substance system of care. As such I voluntarily authorize BPA Health, those Substance Abuse Treatment and Recovery Support Services (RSS) providers who are contracted to provide Treatment and RSS under Idaho's publicly funded substance abuse system of care, and the Department of Health and Welfare (Department) to disclose my name, all necessary treatment information and my social security number to each other and the Department. This information will be disclosed for the following purposes: **1)** To assist with referring me to appropriate types of care and guiding my treatment and recovery support; **2)** To be entered into the Department's common client database so that I will have one client number for any services received from the Department; **3)** To process payment of costs for my treatment and recovery support services; **4)** For monitoring compliance in the program; **5)** For programming audit and research including independent peer reviewers, contract monitors or researchers appointment by the Department; **6)** For investigations related to fraud.

Furthermore, I authorize the disclosure of personal substance abuse treatment and recovery outcomes data collected by contracted Substance Abuse Treatment and RSS Providers, BPA Health and the Department to the Federal Center for Substance Abuse Treatment and its contracted data collections Agents. _____, **Client initials**

Informed and Voluntary Consent for Treatment

The purpose of my participation, as a client, in the Idaho publicly funded substance abuse treatment program is to acquire knowledge, skills and attitudes supportive of a sober and more satisfying lifestyle. In addition to the potential positive outcomes likely to occur as a result of my participation, the following reasonably foreseen risks may occur, as they would in any other alcohol and drug treatment program: breach of confidentiality; negative reactions of group members; emotional stress from requirements of group interaction, self-disclosure; stress to relationships resulting from open discussion of issues, past traumas; and stress to relationships resulting from participant behavioral changes, positive or negative, need to attend recovery support meetings, spend time in group and doing assignments.

Providers will take steps to minimize or protect participants against potential risks by adhering to standards of confidentiality found both in Federal and State Code, and by informing and verifying client understanding of group rules. And, by intervening in and guiding appropriate disclosure, confrontation and resolution in group and in family conflict. Providers will assist clients in accessing sober support services and self-help groups where acceptance and stress reducing support is available. _____, **Client initials**.

Revocation Clause

This release may be revoked at any time either orally or in some writing, except to the extent that action has already been taken in reliance on the release. I acknowledge that some information may include material that is protected by State and Federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Record, 42 C.F.R. Part 2 and the Health Information Portability and Accountability Act (HIPAA). Unless revoked as stated above, this consent expires automatically on: _____. _____, **Client initials**.

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

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

Client Printed Name

Client Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

Witness Printed Name

Witness Signature

Date



WHODAS 2.0

WORLD HEALTH ORGANIZATION

DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

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

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

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

Please continue to next page...



WHODAS 2.0

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

This completes the questionnaire. Thank you.

PATIENT HEALTH QUESTIONNAIRE- 9

(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please Circle your response

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

FOR OFFICE CODING	0	±		±		±	
= Total Score:							
If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?							

Please check your response below:

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral Health-Health Questionnaire

Client's Name:

Today's Date:

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

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

Acuity Check

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

Medical

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

- | | | | |
|---|---------------------|---------------------------|--------------------|
| -Community Health Center | -Urgent Care Center | -Dentists | -Private Community |
| -Physician Pain Management Services | -Methadone Clinics | -Hospital Emergency Rooms | |
| -Specially Medicine (i.e. Immunization, Neurology, Cardiology, and Endocrinology) | | | |

General Health

1. Who is your Primary Care Physician?
2. What was date you were last seen?
3. How many times have you visited an Emergency Room in the past 30 days?
4. How many days in the past 30 have you stayed overnight in a hospital for physical health problems?
5. How many days in the past 30 have you experienced physical health problems?

6. Are you able to perform activities of daily living: bathing, shopping, cleaning, use of transportation?

PERTINENT HISTORY

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

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

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

9. Psychiatric/Behavioral History:

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

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

12. Age at onset:

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

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

MEDICAL HISTORY

15. List of Current Medications:

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

30. Family (parents, Siblings, Children, etc.)				
31. Current Service providers:				
SUBSTANCE ABUSE				
32. Indicate if GAIN is recommended:				
33. Substance Use History (what, when, frequency, amount, impact on mental health)				
34. Family History of drug/alcohol use: (what, when, frequency, amount, impact on mental health)				
35. Substance Use Treatment (historical and current treatment, outpatient and inpatient, when, where, duration, outcome, treatment needs):				
36. Drugs of choice (indicate C=current/P=past)				
37. Current substance use/dependence (what and how often)				
Alcohol	Currently	Sometimes	Never	
Illicit Drugs	Currently	Sometimes	Never	
38. Are you in withdrawal today?	No	Yes	If yes, from what substance(s)?	
39. Do you have frequent blackouts?	No	Yes	How frequently?	
40. Are you currently smoking/ingesting marijuana?	No	Yes	Medical Marijuana Card?	No Yes
41. Date last smoked/ingested:				

42. Have you ever overdosed on alcohol or other drugs? When?	No	Yes	if yes on what?
43. Do you currently use tobacco? day, # of dips)	No	Yes	if yes, how? Smoking, Chewing, Other How much; (# Packs a
44. Do you currently use a Vape?	No	Yes	% of Nicotine
FUNCTIONAL ASSESSMENT			
45. School/Education (current grade attending or highest grade completed/further education. (Diploma, GED, etc.)			
46. Current and Previous Employment (full time/part time and names of employers, dates)			
47. If unemployed: Currently seeking employment?			
48. Military Service (active, inactive, veteran)			
49. Needs:			
FINANCIAL			
50. Sources of Income			
51. Skills for managing finances (budgeting, bill payment, etc.):			
SOCIAL			
52. Interests (leisure and recreational)			

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

64. Identify membership in church, clubs, and other groups:

65. Do you have any religious, cultural, physical or other factors that might influence your care?

66. Needs:

LEGAL

67. History of criminal justice involvement (arrests, warrants, parole/probation or jail time):

68. Involvement with CPS:

69. Needs:

70. Are you experiencing any of the following: (Circle all that apply)

Ankles Swollen
Bleeding Problems,
Bruising easily
Chest pain(angina)
Cough; persistent or bloody
Diarrhea, constipation, blood
in stools
Dizziness or fainting
Fever

Headaches
Jaundice-frequent yellowing
of skin
Joint pain or stiffness
Excessive heartburn or
Abdominal pains
Chronic back pain
Nausea and vomiting
Rashes
Seizures

Shortness of breath
Sinus Problems
Swallowing difficulty
Thirst excessive
Tooth or gum problems
Urination frequent or bloody
Vision-blurred or double
vision
Weight gain

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

Arthritis
Artificial Joint
Asthma
Emphysema
Chronic bronchitis

Diabetes
Anemia
Blood Transfusions
Cancer

Chemotherapy/Radiation
High Blood Pressure
Low Blood Pressure
Stroke – if yes give details:

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

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

Date of heart attack:

Medical Interventions such as bypass, stint, etc.:

74. Women Only

No Yes Are you pregnant? Due Date:

No Yes Breast feeding?

No Yes Have you had any miscarriages or abortions?

No Yes Do you have difficult periods?

What age did you start your first period?

Date of last period?

No Yes Any current or past domestic abuse?

No Yes Do you have pain with intercourse?

No Yes Abnormal mammogram or lump?
Date:

No Yes Abnormal PAP? Date:

Date of last GYN exam:

75. Communicable Diseases

No Yes Have you ever been tested for TB?

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

Consent to Release Protected Health Information (PHI)

Magellan Healthcare, Inc.
 Attention Privacy Officer, Collaborative Care
 14100 Magellan Plaza, Mail Stop MO41
 Maryland Heights, MO 63043

Managing the Collaborative Care Program for:
Community Health Development, Inc.

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors at Community Health Development, Inc. your PHI unless you say it is **OK**. By signing this paper, you give us your **OK**. We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call Magellan Healthcare, Inc. (Magellan) at 1-800-201-3957, Option 3 or read the separate instructions page for more information on how to complete this form.

Part 1 Who is the patient?

Last Name		First Name		Middle Initial
ID Number	Date of Birth (MM/DD/YYYY)		Phone Number (with area code)	
Address		City	State	Zip Code

Check One (to tell us who is filling out this form):

- ☐ I am the patient OR
- ☐ I have the legal right to act for this person. (Check one below; if "Guardian/Other" fill your name in blank)
- I am his or her: ☐ Parent OR
- ☐ Guardian/Other (Legal Proof Required) _____

Part 2 Who can give out the PHI?

Magellan may give out your PHI. Magellan manages your mental health and/or drug and alcohol treatment through the Collaborative Care program for Community Health Development, Inc.

Part 3 Who can the PHI be given to?

Name (a person, like a family member or doctor, or a place like a clinic or hospital): Cognitive Restructuring	Phone Number (with area code) (208) 242-3044
Address: 707 North 7th Avenue, Suite D	City, State, and Zip Code Pocatello, Idaho 83201

Part 4 What PHI can we share?

We will **only** share the PHI that you **OK**. This **OK** includes facts about your medicine. It also includes facts about your mental health and/or your alcohol and drug treatment that are in your records. It does not cover psychotherapy notes that are not in your records. Tell us the health information from your records that can be shared. _____

If you give us your **OK** to share this kind of health information in the above PHI, check the boxes that apply:

- ☐ HIV/AIDS ☐ Alcohol/Substance Abuse Records

Part 5 Why are you giving out this PHI?

Tell us why you want us to share your PHI? _____

Turn this page over.

Part 6 When does my OK end?

Your OK will end when you tell us it does. Tell us when you want your OK to end:

☐ My OK ends on this date: _____ (It cannot be more than one year from your OK)
OR

☐ My OK ends when this happens: _____
(It can be something like "you can share my PHI this one time.") If you do not tell us when your OK ends, then we will end your OK in one year from when you sign. After one year, we will need a new OK.

Part 7 Your Rights and Important Facts

- i Giving your OK is up to you. You do not have to share your information.
- i You do not have to OK this paper. You will still get benefits and treatment.
- i You can take back your OK. You must tell us in writing. Mail it to: Magellan Healthcare / Attention Privacy Officer, Collaborative Care / 14100 Magellan Plaza, Mailstop MO41 / Maryland Heights, MO 63043. Or you may fax it to 1-888-656-4769.
- i What if you take back your OK? This will not take back the PHI that we have already shared. But, we **will not** share any more of your PHI.
- i If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- i You have a right to get a copy of this signed OK. If you need another copy, call Magellan at 1-800-201-3957, Option 3.
- i If you do not understand, or have questions, we can help. Call Magellan at 1-800-201-3957, Option 3.
- i If you decide to complete this form and give your OK, send it to us at the address or fax # listed above.
- i You should keep a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your address and date of birth. A full definition of PHI is at 45 CFR §160.103.

Part 8 Signature of Patient

I give my OK to share the information listed in this paper.

Signature or Mark of Patient

Date (required)

Part 9 Signature of Authorized Representative (if any)

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor. If you have legal proof that you can act for this person, please send a copy of the proof with this form.

Signature of Person signing on behalf of patient

Date (required)

Printed Name:

Phone:

Address:

NOTICE TO ANYONE OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited 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 sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.