Wil la mootk Counseling Center
P.O. Box 8 Metlakatla, AK 99926
[P] - (907)886-6911 [F] - (907)886-6917

We must have the following documents in order for us to start services.

Please bring copies along with this application.

- **Social Security Card**
- **Birth Certificate**
- **Proof of Guardianship (if not listed on birth certificate)**
- **Denali-Kid Care card or Medicaid**

If you have any questions regarding this application or about anything listed above, please feel free to call our office at (907)886-6911 any time from 9:00am to 4:30pm Monday thru Friday.

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CLIENT PROFILE

Youth's Name: _____ (First / Middle / Last) Alternate Name(s): _____

Gender: ☐ Female ☐ Male Birthdate: _____ Age: _____

Social Security Number: _____ Medicaid Number: _____

Home/Physical Address: _____ (City / State / Zip)

Mailing/Billing Address: _____ (Box Number / City / State / Zip)

Parent/Guardian: _____ Relationship to Youth: _____

Email: _____

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

Emergency Contact Number: _____ Relationship to Youth: _____

Youth's Race

☐ Aleut	☐ Black/African American	☐ Native Hawaiian	☐ Yupik
☐ American Indian	☐ Caucasian	☐ Pacific Islander	☐ Other Alaska Native
☐ Asian	☐ Haida	☐ Tlingit	☐ Other
☐ Athabascan	☐ Inupiat	☐ Tsimshian	(Specify): _____

Youth's Ethnicity

☐ Not Spanish, Hispanic Latino Mexican	☐ Cuban	☐ Mexican American	☐ Spanish/Hispanic Latino
☐ Chicano/Other Hispanic	☐ Hispanic-Specific origin not specified	☐ Puerto Rican	☐ Unknown

Special Needs

☐ None	☐ Moderate to Severe Medical Problems	☐ Visual Impairment or Blind
☐ Developmentally Disabled	☐ Organically Based Problem	☐ Major Difficulty in Ambulation or Non-ambulation
☐ Severe Hearing Loss or Deaf	☐ Other	
☐ Traumatic Brain Injury (TBI)	☐ Unknown	

Has youth ever received services from our agency (Counseling, etc.)? ☐ Yes ☐ No
If yes, when and what type of services did your youth receive?

Is your youth currently receiving mental health and/or substance abuse services from another agency? ☐ Yes ☐ No
If yes, Which agency and what type of services?

Why was youth referred to Wil la mootk Counseling Center?

Wil la mootk Counseling Center

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Financial/Household Information

Primary Income: *check one*

- ☐ None
- ☐ Alimony
- ☐ Employment
- ☐ Public Assistance/Welfare Pay
- ☐ Retirement/Serv/Disability Pension
- ☐ SSI/SSDI Never
- ☐ Tribal Assistance Programs
- ☐ Alaska PFD
- ☐ Interest & Other
- ☐ Parent's Income
- ☐ Social Security Disability (SSDI)
- ☐ SSI/SSDI Previous
- ☐ Alaska Native Corp. Dividends
- ☐ Child Support
- ☐ Other
- ☐ Spouse/Significant Other Income
- ☐ SSI
- ☐ Unemployment Compensation

Household Income: *Check one*

- ☐ 0-$999
- ☐ $1,000-4,999
- ☐ $5,000-9,999
- ☐ $10,000-19,999
- ☐ $20,000-29,999
- ☐ $30,000-39,999
- ☐ $40,000-49,999
- ☐ $50,000 and over

Expected Payment Source: *Check one*

- ☐ Medicaid/Denali: #_____
- ☐ Aetna
- ☐ Blue Cross/Blue Shield
- ☐ CIGNA
- ☐ Other Public (specify)_____
- ☐ Other Private: (specify)_____
- ☐ Client Self-Pay

Household Composition: *check one*

- ☐ Client Lives Alone
- ☐ Lives with Adolescents
- ☐ Lives with Children
- ☐ Lives with Non-relatives
- ☐ Lives with Relatives
- ☐ Lives with Significant Other(s)
- ☐ Significant Other & Children
- ☐ Other:

(specify)_____

Living Arrangement: *check one*

- ☐ Assisted Living Facility
- ☐ Correction/Detention Facility
- ☐ Crisis Residence
- ☐ Foster Care
- ☐ Group Home
- ☐ Halfway House
- ☐ Homeless
- ☐ Shelter
- ☐ Nursing Home
- ☐ Transitional Housing
- ☐ Therapeutic Foster Care
- ☐ Private Residence w/out supportive services
- ☐ Private Residence w/supportive services
- ☐ Residential Treatment
- ☐ Hospital (non-psychiatric purposes)
- ☐ Hospital (psychiatric purposes)

Number of people living with you: Number of children in household:

Names of Family Members living in Home	**Age**	**Relationship**

Parent/Guardian Signature:_____ **Date:**_____

AKAIMS Entry For Official Use Only	AKAIMS Client #	Entered by: Date:

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CONSENT FOR TREATMENT OF MINOR CHILD

I, _____, hereby authorize Wil la mootk Counseling Center to evaluate, test and/or treat minor child, _____.

Specific concerns, if any:_____

_____

_____

_____ _____

Parent Date

_____ _____

Legal Custodian (OCS, Juvenile Probation) Date

_____ _____

Legal Guardian (proof of guardianship must be provided) Date

_____ _____

Witness Date

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I (parent/ guardian) _____, acknowledge that by requesting my child, _____, be picked up and dropped off at different locations and homes I am allowing Wil la Mootk staff to verify my child's affiliation with Wil la Mootk Counseling Center. I understand that if I do not want Wil la Mootk to verify my child's affiliation, that means we can no longer provide transportation unless the pick up is at my current living address. All records and treatment details will be kept confidential and in compliance with Release of Confidential Information on file.

_____ Date_____
(Client Signature)

_____ Date_____
(Parent/ Guardian Signature)

_____ Date_____
(Witness)

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FINANCIAL CONSENT

State grants, contracts and client fees fund the Wil la mootk Counseling Center.

Clients will be charged a fee according to their ability to pay; however, no one will be denied services because of an inability to pay. This fee will be based on your annual gross family income and the number of people dependent upon that income. All services are rendered without exclusion or discrimination on the grounds of race, color, creed, national origin, or disability.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND PAYMENT OF MEDICAL BENEFITS TO WIL LA MOOTK COUNSELING CENTER. Wil la mootk Counseling Center will restrict disclosure to reasonably necessary information. This means Wil la mootk Counseling Center will only communicate limited information to insurance companies when it is reimbursable (pursuant to 42, CFR part 2).

Fees must be paid at the time of appointment unless other arrangements have been made. **Missed appointments may be billed at a flat fee of $20.00 unless canceled at least 24 hours in advance.**

This is to certify that the above information is true and accurate to the best of my knowledge, and that I will be responsible for all financial obligations according to my set fee, which was established in my presence.

SIGNATURE **DATE**

WITNESS **DATE**

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Client Rights and Responsibilities

Policy

It is the policy of Wil la mootk Counseling Center (WLM) to respect the rights of clients. Clients receive in writing a statement of their rights and responsibilities while receiving care at Wil la mootk Counseling Center.

Clients have the right:

A. To receive care from WLM within our capability and mission and in compliance with the law.

B. To have their cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.

C. To personal dignity.

D. To be informed about what forms of treatment are available.

E. To be involved in decisions about care, treatment, and services provided.

F. To review their own record with clinical staff supervision and obtain a timely response to the request for copies of their record.

G. To the confidentiality of their records except when released by written consent, court ordered, or reported anonymously as statistics.

H. To view their billing records and obtain a timely response to the request for copies of that record.

I. To file a grievance as established by company policy.

J. To refuse care in accordance with law and regulation.

K. To be informed about the outcomes of provided treatment, including unanticipated outcomes.

L. To be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.

M. To protective and advocacy services.

N. To know the name, purpose, and side effects of any medications prescribed.

O. To appropriate referrals that reflect the foregoing rights and values

Clients have the responsibility:

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A. To actively participate in treatment.

B. To provide accurate and complete information to their care provider during care.

C. To ask questions when they do not understand an aspect of their care.

D. To follow mutually agreed upon guidelines or instructions during treatment.

E. To accept the consequences if treatment guidelines or instructions are not followed.

F. To follow the rules such as the smoking policy, timely arrival for appointments, and the maintenance of the confidentiality of other clients.

G. To be respectful and considerate of staff, clients, visitors, and property.

H. To meet payment obligations. This is in regards to providing WLM with proper insurance information, such as a correct Medicaid number or other insurance number, informing WLM if there has been a change in insurance, or if client is no longer eligible for Medicaid or other insurance.

I have read and agree with the Rights and Responsibilities.

_____ _____

Client Date

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

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I _____ authorize the release of confidential information between
(Parent/guardian)

Wil la mootk Counseling Center and the

ANNETTE ISLAND SCHOOL DISTRICT for _____.
(Client/Individual)

- I give all of the Wil la mootk staff permission to check out and transport my child to and from school for their appointments with Wil la mootk Counseling Center. _____(Initial)

Please INITIAL all information to be released:

	Psychological Evaluations and Assessments		Treatment Plans
	Educational Records including IEP's		History of Alcohol and Substance Use
	Psychiatric Evaluations and Assessments		Psychological and Social History
	Mental Health Assessments and Evaluations		Therapeutic Foster Services
	Medical Diagnosis and Records		Other (specify):

This protected information is being used for diagnostic or treatment purposes.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon to date. If not previously revoked, this consent will terminate 90 days from the date of completion of treatment services or discharge from program.

_____ Date_____
(Client signature)

_____ Date_____
(Parent/guardian)

_____ Date_____
(Witness)

Prohibition on redisclosure: This information has been disclosed for records whose confidentiality is protected by federal law. Federal regulations (42CFR part 2) and the Health Portability and Accountability Act of 1996 (HIPAA) 42 u.s.o., prohibits further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense and more than $5000, in the case of each subsequent offense.

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I _____ authorize the release of confidential information between
(Parent/guardian)

Wil la mootk Counseling Centers and the

ANNETTE ISLAND SERVICE UNIT for _____.
(Client/Individual)

Please INITIAL all information to be released:

	Psychological Evaluations and Assessments		Treatment Plans
	Educational Records including IEP's		History of Alcohol and Substance Use
	Psychiatric Evaluations and Assessments		Psychological and Social History
	Mental Health Assessments and Evaluations		Therapeutic Foster Services
	Medical Diagnosis and Records		Other (specify):

This protected information is being used for diagnostic or treatment purposes.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon to date. If not previously revoked, this consent will terminate 90 days from the date of completion of treatment services or discharge from program.

_____ Date_____
(Client signature)

_____ Date_____
(Parent/guardian)

_____ Date_____
(Witness)

Prohibition on redisclosure: This information has been disclosed for records whose confidentiality is protected by federal law. Federal regulations (42CFR part 2) and the Health Portability and Accountability Act of 1996 (HIPAA) 42 u.s.o., prohibits further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense and more than $5000, in the case of each subsequent offense.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I _____ authorize the release of confidential information between
(Parent/guardian)

Wil la mootk Counseling Center and

___METLAKATLA SOCIAL SERVICES_____ for _____.
(Client/Individual)

Please INITIAL all information to be released:

	Psychological Evaluations and Assessments		Treatment Plans
	Educational Records including IEP's		History of Alcohol and Substance Use
	Psychiatric Evaluations and Assessments		Psychological and Social History
	Mental Health Assessments and Evaluations		Therapeutic Foster Services
	Medical Diagnosis and Records		Other (specify):

This protected information is being used for diagnostic or treatment purposes.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon to date. If not previously revoked, this consent will terminate 90 days from the date of completion of treatment services or discharge from program.

_____ Date_____
(Client signature)

_____ Date_____
(Parent/guardian)

_____ Date_____
(Witness)

Prohibition on redisclosure: This information has been disclosed for records whose confidentiality is protected by federal law. Federal regulations (42CFR part 2) and the Health Portability and Accountability Act of 1996 (HIPAA) 42 u.s.o., prohibits further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense and more than $5000, in the case of each subsequent offense.

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I _____ authorize the release of confidential information between
(Parent/guardian)

Wil la mootk Counseling Center and

_____ for _____
(Program/Agency/Individual) (Client/Individual)

Please INITIAL all information to be released:

	Psychological Evaluations and Assessments		Treatment Plans
	Educational Records including IEP's		History of Alcohol and Substance Use
	Psychiatric Evaluations and Assessments		Psychological and Social History
	Mental Health Assessments and Evaluations		Therapeutic Foster Services
	Medical Diagnosis and Records		Other (specify):

This protected information is being used for diagnostic or treatment purposes.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon to date. If not previously revoked, this consent will terminate 90 days from the date of completion of treatment services or discharge from program.

_____ Date_____
(Client signature)

_____ Date_____
(Parent/guardian)

_____ Date_____
(Witness)

Prohibition on redisclosure: This information has been disclosed for records whose confidentiality is protected by federal law. Federal regulations (42CFR part 2) and the Health Portability and Accountability Act of 1996 (HIPAA) 42 u.s.o., prohibits further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense and more than $5000, in the case of each subsequent offense.

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Consumer Rights of Confidentiality

Confidentiality

Your presence here, what you say, and any records kept are, by law, confidential and may be released only with your written consent, except under the following circumstances:

1) Upon receipt of a legitimate court order.
2) In the event of a medical emergency or involuntary commitment.
3) The presence of any reason to suspect that a child has been abused.
4) The presence of any reason to believe that the life of any person is in danger.
5) To validate a claim for payment.
6) In the case of a crime or a threatened crime on the premises of the program or against program personnel.
7) For purposes of an audit of the program's activities.

In any instance when your records must be released without your express consent, information released will be limited to the information necessary for that purpose. If you are under the age of 18, your parent or guardian must give written consent to release information, except under the preceding circumstances.

Your Rights

You are entitled and encouraged to participate in the formulation, evaluation, and periodic review of your *Treatment Plan*. You may request specific forms of treatment, request information about why certain forms of treatment are not being made available, refuse specific forms of treatment, and be informed of treatment prognosis.

You have the right to review your treatment record with a staff member at a prearranged time, with the exception that information confidential to another person may not be reviewed.

You have the right to be informed of the name, purpose, and possible side-effects of any medication prescribed as part of your treatment. You have the right to a written summary of your treatment and *Aftercare Plan*.

Complaint Procedures:

The Civil Rights Laws require that Wil la mootk Counseling Center provide services without distinction to age, race, color, creed, national origin, gender, or disability. Wil la mootk Counseling Center is dedicated to providing professionally appropriate, mutually agreed upon services in a respectful manner. If you have a complaint or grievance, you are encouraged to file a written statement describing the action or situation. The statement should contain your name and address and be filed with the Director of the agency. All complaints are investigated and followed by a written reply. Detailed grievance procedures are posted in each building. Suggestions are always welcome in the suggestion boxes at each location.

If you think there has been a violation of your civil rights, you may also file a complaint with the Department of Civil Rights, Department of Health, Education and Welfare, Region X, 1321 Second Avenue, Seattle, Washington, 98101.

Your signature affirms that you have reviewed the above information, have been given an orientation to the program and give your consent to treatment as determined by you and your therapist and/or treatment team.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

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Limits of Confidentiality

Information discussed in the therapy or group setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including, but not limited to, physical beatings, sexual abuse, emotional abuse, or neglect.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

_____ _____
Name of Parent/ Guardian Date

_____
Signature of Parent/ Guardian

_____
Signature of Staff

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Participant's First Name _____ MI _____ Last Name _____

Hold Harmless Agreement

I understand that participation in the program may involve a certain degree of risk. I have carefully considered the risks involved and have given consent for my child to participate in the program. I understand that participation in the program is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Wil la mootk Counseling Center, and all employees, volunteers, related parties, or other organizations associated with the program from any and all claims or liability arising out of this participation. _____(Initial)

In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardians, and/or determination of the participant's ability to continue in the program activities. _____(Initial)

(_____)_____
Area Code and Phone Number
(**Best contact and Emergency contact**)

_____
Email (for use in sharing more details about the trip or activity)

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

_____ _____
Witness/Staff Signature Date

Contact Wil la mootk Counseling Center if you have any questions or concerns at (907) 886-6911.

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Welcome to Wil la mootk! We are pleased you have chosen our agency and would like to introduce you to the services we offer. We have also included copies of our privacy practices and your rights of confidentiality so that you can refer to this information if needed in the future. Please feel free to contact our staff with any questions you may have.

EMERGENCY SERVICES

Emergency mental health services are available 7 days a week, 24 hours a day. After regular clinic hours, on weekends and holidays, Gateway on-call staff is accessed through the Annette Island Service Unit. The clinic will contact the mental health or substance abuse professional on-call. Please note that Wil la mootk Counseling Center will not physically restrain consumers at any time. The police will be contacted if consumers exhibit behaviors that put themselves or others at risk.

CHILD AND YOUTH SERVICES

The Child and Youth Program offers outpatient and home-based therapy, case management to coordinate and facilitate treatment plans and support and train foster parents. Consultation is available to individuals, agencies and schools. Children and youth who exhibit deficits in functioning with peers, family, school and/or community may be eligible for admission.

INTERMEDIATE CARE SERVICES (KAR HOUSE) – REFERRAL ONLY

The intermediate care component provides residential treatment services to clients from Ketchikan and surrounding communities. The KAR House facility is located at 3134 Tongass Avenue, in front of Ketchikan General Hospital. Treatment services are provided to both male and female adult clients, 18 years of age or older. Treatment stays at KAR House are individualized and usually last between 21 to 45 days. The structure of the program is provided through a client treatment plan, a set of house rules and a schedule of group activities. Family members are invited to participate in the treatment process. A client's responsibility in the program is reinforced through completion of homework assignments, participation in facility chores and maintenance, meal preparation and active participation in all group activities. "Aftercare" is emphasized through residential treatment and an Aftercare Plan is prepared with the client before departure.

OUTPATIENT CLINICAL SERVICES

Wil la mootk Counseling Center maintains a number of skilled clinicians to provide mental health services for a wide variety of human problems. Services are available for children, youth and families. Individuals, families, couples or small groups with related problems are treated for issues including, but not limited to: marital adjustment, parent-child conflicts, individual adjustment, stress management and other common problems. Wil la mootk Counseling Center offers outpatient substance abuse treatment programs that vary in length and intensity depending on the clients' needs. The program includes substance abuse education, group therapy, and relapse prevention groups. Most classes are offered in late afternoon and early evening.

PSYCHIATRIC/PSYCHOLOGICAL SERVICES

Telepsychiatry is offered through Dr. Mia M. Galioto or through referral to Gateway Human Services in Ketchikan. Additional outside referrals may be made based upon physician availability. Evaluations for medication management are provided with periodic medication reviews and treatment supervision. A wide range of psychological testing is done by or under the supervision of a Clinical Psychologist. This includes a range of intellectual, personality and diagnostic tests.

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Notice of Privacy Practices

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

If you have any questions about this Notice please contact our Privacy Officer at 886-6911 or contact via mail at Wil la mootk Counseling Center Post Office Box 8; Metlakatla, Alaska 99926. You may also contact the Office of Civil Rights at 200 Independence Avenue, S.W.; Washington, DC 20201, or reach the Secretary by phone at (202) 690-7000.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION (PHI)

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We understand that your PHI is personal. We are committed to protecting your PHI and to sharing minimum necessary information required to accomplish the purpose. We create a record of the care and services you receive through the Wil la mootk Counseling Center. This notice applies to all of the PHI compiled about you during your care with our agency.

This Notice of Privacy Practices describes how we use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law (see in the body of the Notice). It also describes your rights to access and control your PHI.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. Whenever there is a material change to the uses and disclosures of PHI, we will promptly revise and distribute our Notice and the Revised Notice will be available for you at your next visit to the agency.

I. Uses and Disclosures of Protected Health Information

When you come into our agency there are many forms that you will need to complete and data that you will provide. We are required to compile much of this information by our funders. Your PHI may be used and disclosed by our agency, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing services to you.

Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the provider's practice.

Following are examples of the types of uses and disclosures of your protected healthcare information that we will make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

A. **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare. We will also share information that you provide with supervisors or our internal team members so that they can assist in determining the best course of care and services for you.

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B. Payment: Your PHI will be used, as needed, to obtain payment for the services that we provide. This may include certain activities that your health insurance plan or service funder may undertake before it approves or pays for the healthcare services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan/funder to obtain approval for the hospital admission. We may also disclose your information to another provider involved in your care as part of ensuring your eligibility for services.

C. Healthcare Operations: We may use or disclose, as-needed, your PHI for our own healthcare operations in order to provide quality care to all consumers, to assess staff training needs or to ensure the efficiency of program operations. Healthcare operations include such activities as:

- Quality assessment and improvement activities,
- Employee review activities,
- Training programs including those in which students, trainees, or practitioners in healthcare learn under supervision,
- Accreditation, certification, licensing, or credentialing activities,
- Review and auditing, including compliance reviews, record reviews, legal services and maintaining compliance programs, or
- Business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their healthcare operations.

D. Other Uses and Disclosures: As part of treatment, payment and healthcare operations, we may also use or disclose your PHI for the following purposes:

- To remind you of an appointment,
- To inform you of potential treatment alternatives or options,
- To inform you of health-related benefits or services that may be of interest to you.

II. Other Permitted Uses and Disclosures

- **Others Involved in Your Healthcare:** We may use or disclose PHI to your guardian or personal representative or any other person that is directly responsible for your care. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

- **Communication Barriers:** We may use and disclose your PHI if we attempt to obtain an authorization from you but are unable to do so due to substantial communication barriers that we cannot overcome and we determine, using professional judgment, that you intend to provide authorization to share information.

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[P] - (907)886-6911 [F] - (907)886-6917

III. Other Required Uses and Disclosures

We may use or disclose your PHI in the following situations without your authorization. These situations include:

A. In Connection With Judicial and Administrative Proceedings: We may disclose your PHI in the course of any judicial or administrative proceedings in response to an order of a court or magistrate as expressly authorized by such order or in response to a signed authorization.

B. To A Designated Hospital To Which A Client Is Involuntarily Committed: We may disclose PHI to assure continuity of care.

C. To Report Abuse, Neglect or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of healthcare or public benefits.

E. In a Medical or Psychological Emergency: We may disclose your PHI to direct medical service or mental health personnel if a medical or psychological emergency arises.

F. For Research Purposes: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

G. When Legally Required: We will disclose your PHI when we are required to do so by any Federal, State or local law.

H. Imminent Threat to Health or Safety: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

I. To Division of Mental Health and Developmental Disabilities in accordance with 7 ACC 71.400 - 7 ACC 71.449. We will disclose PHI to DMHDD for health oversight activities specifically identified in Alaska law.

J. For all other disclosures of your PHI we must obtain a written authorization for release of information from you. This authorization must include:

- Specific person to whom the information is being released
- Purpose of the release
- Date of the release –time frame
- Specific information or documents that are being released
- Opportunity to revoke consent.

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IV. Your Rights Regarding Protected Health Information

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

A. Right to Inspect and Copy: You have the right to inspect and receive a copy of your PHI. We may have to charge you for copying. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set. A "designated record set" contains PHI and billing records and any other records that we use for making decisions about you. If we perceive that providing you access to your record constitutes a danger to self or a danger to others, we can use our professional judgment regarding access.

B. Right to Request Restrictions: You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your case record not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

C. Right to Request Confidential Communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make this request in writing. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. We are not required to honor your request, but if we do not do so, we will explain in writing.

D. Right to Amend: You may have the right to amend your case record. This means you may request an amendment of the information in your record for as long as we maintain this information. This request must be in writing and provide a reason for the amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, we will do so in writing. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact your provider if you request an amendment.

E. Right to an Accounting of Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. By law it excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame.

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F. Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

V. Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing, with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer as follows for further information about the complaint process:

Edith Guthrie - Business Manager
P.O. Box 8
Metlakatla, Alaska 99926
PHONE: (907) 886-6911 FAX: (907) 886-6917

You may also file a complaint with the Secretary of Health and Human Services at 200 Independence Avenue, S.W.; Washington, DC 20201, or reach the Secretary by phone at (202) 690-7000.
There will be no retaliation for filing a complaint.

VI. Changes to This Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, in the top right-hand corner, the effective date. You will be offered a copy of the current notice when you visit our officers for services.

VII. Effective Date:

This Notice of Privacy Practices is effective December 21, 2011