CORNERSTONE HEALTH

Medical ▪ Counseling ▪ Recovery

Authorization to Use and Disclose Health Information

Notice: This request is not valid unless all requested information is provided.

Client Identification: Printed Name: _____ Date: _____
Address: _____
Cell Phone: _____ Other Phone: _____

Release To & From: Name: _____Phone: _____
_____Fax: _____

Release To & From: Name: CORNERSTONE RECOVERY Phone: 907.339.8786
2121 Abbott Road, Suite 102 Anchorage, Alaska 99507 Fax: 907.917.4901

Dates of Service to Be Released:
Dates of Service: From: _____ To: _____

Please initial next to each type of information to be released:
___Assessment/Evaluation ___Progress Notes ___Discharge Summary ___Psychiatric Reports

Received by: ___Mail ___Fax ___Pick-up ___Oral Exchange

Purpose of the Request:
___Personal (at the request of the client) ___Treatment ___Legal ___Insurance ___Government ___Other:_____

Terms

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Part 160 and 164, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that as long as I am a client at Cornerstone Recovery my drug and alcohol treatment information will be maintained and included with my electronic health records, which is available to all Cornerstone Recovery providers for the purpose of any treatment I may have at Cornerstone Recovery. The facility, its employees, officers and hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that authorizing this disclosure of the above information voluntary and I need not sign this form to ensure treatment, I understand that the information in may health record may include records relating to sexually transmitted diseases drug and/or alcohol abuse treatment, psychiatric care other sensitive information ____ Please initial.

Exploration & Right to Revoke Authorization

Except to the extent that the law has already been taken in reliance on this authorization, at any time I make revoke this authorization by submitting a notice in writing to Cornerstone Recovery, unless revoked earlier, this authorization will expire in ONE YEAR and can be revoked by the client or their representative in written notice from the date it was signed or upon the following date or event:
_____.

Unless revoked sooner by the client or the client's legally responsible person, a consent for release of information shall be valid for a period not to exceed one years except under the following conditions: A consent for release of information to the Division, Division of Motor Vehicles, the Court and the Department of Correction for information needed in order to reinstate a client's driving privilege shall be considered valid until reinstatement of the client's driving privilege. A consent for release of information received from an individual or agency not covered by the rules does not have to be on the form utilized by our facilities; however, CC shall determine that the content of the consent form substantially conforms to the requirements. A clear and legible photocopy of consent for release of information shall be considered to be as valid as the original.

Signature: _____ Date: _____

If signed by legal representation, relationship to patient:_____

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Informed Consent to Treat

I, _____, hereby consent to participate in treatment with Cornerstone Recovery. Cornerstone Recovery Clinic is committed to treating the whole person. We provide counseling service to nurture you to become a healthy individual and body, soul and spirit. Clinic services are provided by licensed master level clinicians, and Qualified Addiction Professionals (QAP). QAP are under supervision of on-site supervisors. If you have questions about your treatment you can call us at 907-339-8760.

Confidentiality. We place a high value on client privacy; all records are confidential. If cell phones are taken into session, they are not to be used by any person present, including the therapist, without the client's permission. The agency may bring client cases to case consultation or consult with other therapist within the agency. Should one do so, no name or identifying information will be shared. You may give written permission to your therapist to share information with other medical providers, for example, medical or psychiatrist providers, case workers or family.

Legal requirements specify certain conditions in which it is necessary for us to disclose your name and/or your treatment. These requirements are as follows:

1. If we believe you are in danger to yourself and others
2. If we become aware of any involvement you have in the abuse of a children, elderly or disabled person
3. If you were ordered by a judge or court to release your records.

Fees. I understand that if I if my therapist hours extend over the normally scheduled time, I may be responsible for a larger co-pay and anything my insurance company will not cover. Fees also apply to the preparation of assessment and other reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. We will bill your primary carrier as a courtesy when you see a licensed clinician. Insurance co-pays are due at the time of visit. If insurance does not pay you were responsible for your bill. Billing is done through Diversified Healthcare Management, phone number 907-770-2380.

- Assessments $242 per assessment
- Individual therapy/Family counseling $157.00 an hour
- Groups $54.30 an hour – groups are two to three hours long

Client Responsibility. If you cannot attend a scheduled session, please give us 24-hour notice of cancellation. After two no-shows and/or cancellations in a row, you may be subject to termination of services. You will be charge $75 for no shows/late fee cancelation.

Consent is here given to CHA Cornerstone Recovery to administer appropriate treatment. I also consent to the release of information for insurance purposes for my insurance company to Cornerstone Recovery. This signed consent shall remain in effect until it is revoked by client or guardian at which time written notice must be given to withdraw existing consent. I am responsible for all changes generated for services rendered including services not conveyed by my insurance company. I have read this document in a greed to participate in my treatment under the conditions described above. I understand the information contained in this form and all questions have been answered to my satisfaction.

_____ _____

Signature of client Date

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Limits of Confidentiality

The contents of counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without written consent of the client or the client's legal guardian. It is policy of this clinic not to release any information about a client without a signed release of information. Noted expectation are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the Cornerstone Recovery (CR) Staff is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies to plan for suicide, the CR Staff is required to notify legal authorities and make reasonable attempts to notify the family of the intent.

CR will immediately disclose the following information to past victim(s), intended victim(s), current domestic partner, sentencing court, probation or parole officer, local law enforcement agency and local victim advocacy agency and the prosecutor the following:

A. Threatened or actual destruction of property.
B. Threats to violate, attempts to violate or actual violation of child custody or child visitation orders.
C. Threats of physical harm or actual physical harm to any person or pet.
D. Threats to attempt to visit psychological and or emotional harm or abuse to any person.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child or has recently abused a child, the CR Staff is required by law, to report the information to the division of Office of Child Safety in the Department of Health and Social Services AS 47.17.020 and ACC 25.030(a)(1) (J). If a client states or suggest that he or she is abusing or CR staff have reasonable cause to believe that a vulnerable adult, ("**Vulnerable Adult**") has the meaning given (AS 47.24.900. Eff. 11/13/98, Register 148), has suffered harm or is in danger of abuse, a report will be given to Senior Services/Adult Protection services, Department of Administration AS 47.25.010 and ACC 25.030(a)(1)(K).

Parental Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Child's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouses record.

Professional Misconduct

Professional misconduct by health care professionals must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's action, related records may be released in order to substantiate disciplinary concerns.

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Court Orders

Health care professional are required to release records of clients when a court order has been placed.

Minors/Guardianships

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic. Insurance companies and other third-party payers are given information that they request regarding services to the client. Insurance companies and other third-party payers are given information they request regarding service to the clients. Information which may be requested includes types of services, dates/times of services. Diagnosis, treatment plan, may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures. In the event in which the clinical or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to persevere confidentiality. Please list where we may reach you by phone and how you would like us to say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If information is not provided to the agency (below), we will adhere to the following [procedure when making phone calls: first we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail, we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify the agency when we telephone you.

( ) HOME: Phone Number: _____
How to identify: _____
May we say the clinic name: ( ) YES ( )NO

( ) WORK: Phone Number: _____
How to identify: _____
May we say the clinic name: ( ) YES ( )NO

( ) OTHER: Phone Number: _____
How to identify: _____
May we say the clinic name: ( ) YES ( )NO

I agree to the above of limits of confidentiality and understanding their meanings and ramifications.

_____
Client Print Name

_____ _____
Client Signature Date

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Telehealth Informed Consent

I, _____, hereby consent to participate in Telehealth with Cornerstone Recovery, as part of my psychotherapy. I understand that Telehealth health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Telehealth health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, nor program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with Telehealth health, including but not limited to, disruption of transmission buy technology failure, interruption and/or breaches of confidentiality by unauthorized persons, and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosure to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telehealth health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse, danger to self or others, I raise mental/emotional health as an issue in legal proceeding).
5. I understand that id I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolve remotely, it may be determined that Telehealth health services are not appropriate, and a higher level of care is required.
6. I understand that during a Telehealth health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart session. If we are unable to reconnect within ten minutes, please call Cornerstone Recovery at 907.339.8760.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

EMERGENCY PROTOCOL

Cornerstone Recovery needs to know your location in case of an emergency. You agree to inform Cornerstone Recovery of the address where you are at the beginning of each session. I also need a contact person on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is:

_____ and my emergency contact person's name, address, phone number:

_____

I have read the information provided above and discussed with my clinical. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client Date

_____ _____

Signature of clinician Date

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APPOINTMENT REMINDER CONSENT FORM

Cornerstone Recovery now operates a service which enables us to contact you by text message to confirm appointments ONLY. The appointment reminder service will send you a reminder the day before your scheduled appointment. You can request to cancel/reschedule your appointment through this text messaging service. If you wish to receive these text messages, please read the declaimer below then complete and sign this form.

If you're mobile number changes you need to remember to keep us up to date with your new number. Cornerstone Recovery cannot be held responsible for messages sent to a mobile telephone number you have supplied but you no longer own, or if someone has access to your phone and can view your messages.

As a reminder, it is the policy of Cornerstone Recovery that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time. If an appointment is not cancelled or a client fails to show up for an appointment after the second time, Cornerstone Recovery will charge a fee of $75. As this fee is not billed to any insurance company, the client accepts full responsibility to pay this fee.

I have read the above information and give my consent to be included in this appointment text message service.

I understand that this service is optional and I can STOP it at any time.

I would like to receive reminder text messages.

☐ Yes ☐ No

_____ _____

Cell Phone Number Cell Phone Carrier

_____ _____

Signature of client Date

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MEDICATION LIST

Patient's Name: _____ Doctor's Name: _____

DOB: _____

PRESCRIBED MEDICATION:				
MEDICATION NAME(s)	PURPOSE	DESCRIPTION	DOSAGE	FREQUENCY
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

_____

Client's Print Name

_____ _____

Client's Signature Date