3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Date: __________

Patient Information

Patient: ____
Last Name **First Name** **Middle Initial**

Date of Birth: ________________ Age: ________________ Gender: M / F

Social Security #: ______-____-________ Primary Care Physician: ________________

Employer: ______________________ Occupation: ______________________

Were you referred- if so, who referred you?

____

Contact Information

Mailing Address: ____

Home Phone: ____________________ Mobile Phone: ____________________

Work Phone: ____________________ Email: ____________________

***Please circle the number above that you prefer to be used for appointment reminder calls.**

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Insurance Information

Please provide all insurance policies.

Primary Policy#: ________________________________ Group #: ________________

Policy Holder: __________________________________ DOB: ____________

Social Security #: ________-_____-__________

Effective Date: _______/_________/_________

Secondary Policy#: _______________________________ Group #: _______________

Policy Holder: ___________________________________ DOB: ____________

Social Security #: _________-_____-__________

Effective Date: _______/_________/_________

Tertiary Policy#: _________________________________ Group #: _________________

Policy Holder: ____________________________________ DOB: ____________

Social Security #: _________-_____-__________

Effective Date: _______/_________/________

***Please send us a copy of your insurance card and I.D. as well.**

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Group Policy Agreement

It is the intent of Rainforest Recovery Center Outpatient Services that all patients shall be informed of their responsibilities for group services as follows:

1. I will be on time.
2. I will be respectful of others.
3. I will be respectful of personal boundaries.
4. I will be respectful of each other's feelings.
5. I will not make fun of others.
6. I will take care of personal business before group.
7. I will attend groups alone (no family members or friends in the same room as you).
8. I will maintain the confidentiality of other patients I have encountered. (What is discussed in group stays in the group).
9. I agree not to cross talk over others.
10. I will wait my turn to speak.
11. I will use "I feel" statements.
12. I will own my own feelings.
13. I will not make racist or sexist remarks.
14. I will work my own program.

I hereby certify that I have read and have been fully informed of the Rainforest Recovery Center Outpatient Services Group Policy Agreement. I accept the treatment goals negotiated with the clinical staff and agree to actively participate in my treatment program.

______________________________________ ____________

Patient/Parent or Legal Guardian Signature **Date**

______________________________________ ____________

Witness Date

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Patient's Rights and Responsibilities

Policy: It is the intent of Rainforest Recovery Center Outpatient Services that all patients shall be informed of their legal rights pertaining to services rendered as follows:

Rights:

1. Each patient is entitled to participate in the development and evaluation of his/her treatment plan/goals.
2. Each patient may expect reasonable continuity of care and to be informed of his/her present progress and prognosis.
3. Each patient shall be informed of the name, purpose, and possible side effects of any medication that is prescribed for him/her by a licensed physician under this program as part of the treatment plan.
4. Each patient is entitled to examine and receive explanation of his/her billing regardless of the source of payment.
5. All records and information about patients and former patient shall be safeguarded and kept confidential with the exception that this information be disclosed to the following:

a) A person authorized by court order;

b) A designated hospital to which a patient is involuntarily committed; c) Insurance, medical assistance, or other program only to the extent necessary for a patient to make a claim, or for a claim to be made on behalf of a patient.

d) Other persons to whom disclosure is required by law, an individual to whom the patient, patient's parent (if patient is a minor), legal guardian, or other legal designated representative has been given written consent for disclosure; and

Public Safety personnel in the case of medical or psychological emergency.

_______________________________________ ____________

Patient/Parent or Legal Guardian Signature **Date**

_______________________________________ ____________

Witness Date

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Patient's Rights and Responsibilities

Responsibilities:

1. To actively participate in your treatment.
2. To inform your psychiatrist of events, emotions, plans and commitments which may affect your treatment.
3. To maintain the confidentiality of other patients you may encounter during the course of your treatment.
4. To fulfill commitments made with your psychiatrist, including mutually agreed upon homework assignments.
5. To arrive on time for appointments, informing us a minimum of 24 hours in advance if the session must be canceled (you may be charged up to the full cost of the scheduled service if missed, but not canceled).
6. To pay for each appointment prior to the appointment unless other arrangements are made.
7. To update our office of any changes to your insurance policy.

Rainforest Recovery Center Outpatient Services personnel are required by State Law to report to Alaska Division of Family and Youth Services (DYFS), any known or suspected incident of neglect, abuse and/or sexual molestation of child or other vulnerable person.

I hereby certify that I have read and have been fully informed of the Patient's Rights and Responsibilities and hereby agree:

1. To accept the treatment goals negotiated with the clinical staff and to actively participate in my treatment program.
2. To accept full responsibility for the payment of all charges incurred at Rainforest Recovery Center Outpatient Services.

If you're current treatment recommendation is for ASAM level 2.1, Intensive Outpatient treatment group, this means you will need to attend a minimum of 9 total hours per week of substance abuse treatment. Your 9 hours of treatment can include, psychiatric care and medication management appointments, individual mental health and substance use counseling, and group therapy. If you are involved with an outside agency, such as OCS, Juneau courts/probation, JASAP etc… and have been mandated to obtain an assessment and follow treatment recommendations, it is your personal responsibility to attend the mandated 9 hours of treatment per week in order to be compliant with ASAM 2.1 Intensive outpatient treatment. We want you to be successful in your treatment, and while we do discharge patients for obtaining less than the recommended 9 hours per week of treatment, we do want you to be aware that we are unable to sign off on compliance with treatment if you have not attended the requisite number of 9 hours of treatment per week, and this could have negative consequences for you with the other agencies from whom you are mandated for treatment.

____ ____________

Patient/Parent or Legal Guardian Signature **Date**

____ ____________

Witness Date

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the Bartlett Regional Hospital (BRH) Privacy Notice that describes how my health information is used and shared. I understand that BRH has the right to change this notice at any time. I may obtain a current copy by contacting the BRH Patient Access Services office or by visiting the BRH website at www.bartletthospital.org.

My signature below constitutes my acknowledgement that I have received a copy of the notice of privacy practices.

_______________________________________ __________________

Patient/Parent or Legal Guardian Signature **Date**

If signed by legal representative, relationship to patient:______________________________

If signature not obtained, reason why____
(e.g.: patient refused, etc.)

_______________________________________ __________________

Signature of BRH Employee/Witness Date

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

Patient Name: ______________________ Birth Date:_____________ Medical Record # (if known)_______________

Address: ______________________ City / State/ Zip: ___________________________

I Hereby Authorize Bartlett Outpatient Psychiatric Services to Release Information TO:

Name of Facility/ Organization / Individual: ______________________

Address: ______________________

City / State / Zip: ______________________ Phone Number: _________________ FAX: ______

I Hereby Authorize Bartlett Outpatient Psychiatric Services to REQUEST Information FROM:

Name of Facility/ Organization / Individual: ______________________

Address: ______________________

City / State / Zip: ______________________ Phone Number: _________________ Fax _________

- ❑ Dates of treatment: From____________________To______________________________
- ❑ Purpose or need for information being requested: **Please Initial**
  Further Treatment ______ Legal Proceedings __________ Insurance Claim _________ Other (specify): ______________________
- ❑ Type of Information to be used or disclosed: **Please Initial**
  ______ Consultation ________ History & Physical ________ Progress Notes ________ Verbal Exchange
  ______ Discharge Summary ________ Psychiatric Emergency Evaluation ________ Fax

I authorize the release of information relating to: Please Initial
_______Substance Use Disorder Information ________Psychiatric Evaluation / Treatment

This Authorization expires on the following date, event or condition:______________________________

If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

** I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must submit a written revocation to the BOPS HIM Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
** I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at BOPS.
** I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.
** I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, BOPS their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
** I understand that my alcohol and / or drug treatment records are protected under 42 CFR, Part 2 and 45 CFR, parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

______________________ ______________________ ______________
Signature of Patient or Legally Responsible Party | Relationship to patient | Date

For Office Use Only:
ID Verified & Medical Records Released By: ______________________ Date: _____________
MR #: ________________ Date Records Mailed/Faxed/Picked Up: ________________ Therapists initials: _______

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Client Information

Race:

- ☐ Aleut
- ☐ American Indian
- ☐ Asian
- ☐ Athabaskan
- ☐ Black/African American
- ☐ Caucasian
- ☐ Haida
- ☐ Hispanic
- ☐ Native Hawaiian
- ☐ Inupiat
- ☐ Pacific Islander
- ☐ Tlingit
- ☐ Tsimshian
- ☐ Yupik
- ☐ Other Alaska Native ____________
- ☐ Other ________________________

Ethnicity:

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

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Female Becoming Male
- ☐ Female Formerly Male
- ☐ Male Formerly Female
- ☐ Male Becoming Female

Maiden name (if applicable): ________________ **Pregnant** (if applicable): ☐ Yes ☐ No

Education: (highest level completed)

- ☐ Kindergarten
- ☐ 1st Grade
- ☐ 2nd Grade
- ☐ 3rd Grade
- ☐ 4th Grade
- ☐ 5th Grade
- ☐ 6th Grade
- ☐ 7th Grade
- ☐ 8th Grade
- ☐ 9th Grade
- ☐ 10th Grade
- ☐ 11th Grade
- ☐ High School Diploma -Not GED
- ☐ General Education Degree Graduate
- ☐ Work -No Degree
- ☐ Baccalaureate Degree-BA,BS
- ☐ Master's Degree
- ☐ Doctorate/Professional Degree
- ☐ Post Secondary 1 Year
- ☐ Post Secondary 2 Yrs - Inc AA Degree
- ☐ Post Secondary 3 Years
- ☐ Post Secondary 4+ Yrs -No Degree Special
- ☐ Education Ungraded Classes Vocational
- ☐ Training Beyond High School
- ☐ Other
- ☐ No Schooling

Special Need:

- ☐ None
- ☐ Developmentally Disabled
- ☐ Learning Disorder: Type: _________
- ☐ Other: ______________________
- ☐ Traumatic Brain Injury
- ☐ Visual Impairment /Blind
- ☐ Major Difficulty in Ambulating or non-ambulating.
- ☐ Moderate to severe medical problems
- ☐ Hearing Impairment /Deaf
- ☐ Intellectual Disability/Impaired Cognitive Functioning

Veteran Status:

- ☐ Never in Military
- ☐ Active Duty; No Combat
- ☐ Active Duty; Combat
- ☐ Military Dependent
- ☐ Veteran; Other Eras
- ☐ Retired from Military; No combat
- ☐ Retired from Military; Combat
- ☐ Vietnam Era Vet; Combat
- ☐ Vietnam Era Vet; No Combat
- ☐ Gulf War Veteran; Combat
- ☐ Afghan War Veteran; Combat
- ☐ In Reserves or National Guard; Combat
- ☐ In Reserves or National Guard; No Combat
- ☐ Iraq War Veteran; Combat

Are you an injection drug user? ☐ Yes ☐ No

Have you ever experienced, or are you currently experiencing violence in an intimate relationship? ☐ Yes ☐ No

Print Name:____

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Prior Clinical Admissions and Hospitalizations

Number of Prior Substance Abuse Treatment Admissions?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Number of Prior Substance Abuse related hospitalizations in the last 6 months?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Number of Prior Mental Health Treatment Admissions?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Number of Prior Mental Health Hospitalizations?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Employment Status:

- ☐ Employed Full-time
- ☐ Employed Part-time
- ☐ Disabled
- ☐ Homemaker
- ☐ Not in Labor force - Other
- ☐ Not in Labor for - Resident/Inmate
- ☐ Seasonal Employ; In Season
- ☐ Seasonal Employ; Out of Season
- ☐ Unemployed - Seeking Work
- ☐ Unemployed - Not Seeking Work
- ☐ Unemployed - Subsistence lifestyle
- ☐ Not Seeking Work
- ☐ Other
- ☐ Retired
- ☐ Student
- ☐ In Armed Forces

Expected Payment Source: (How will services be paid?)

- ☐ Aetna
- ☐ Blue Cross/Blue Shields
- ☐ Medicaid
- ☐ Other Private Insurance
- ☐ Other Government Grant
- ☐ Other Public Insurance
- ☐ Client Self-Pay
- ☐ CIGNA
- ☐ HMO

Marital Status

☐ Single ☐ Separated ☐ Cohabitating ☐ Married ☐ Divorced ☐ Widowed

Living Arrangement:

- ☐ Foster Care
- ☐ Assisted Living Facility
- ☐ Correctional Halfway House
- ☐ Group Home
- ☐ Homeless
- ☐ Hospital for Psychiatric Purposes
- ☐ Hospital/Non-Psychiatric Purposes
- ☐ Jail /Correctional Facility
- ☐ Crisis Resident
- ☐ Nursing Home
- ☐ Private residence w/ support
- ☐ Private residence w/o support
- ☐ Residential treatment
- ☐ Shelter
- ☐ Other:
- ☐ Therapeutic Foster Care

Legal Status:

- ☐ 30 Day Commitment
- ☐ 90 Day Commitment
- ☐ 180 Day Commitment
- ☐ Case pending Community sentencing
- ☐ Furlough/ Rehabilitation
- ☐ Emergency Commitment
- ☐ Deferred Prosecution
- ☐ Deferred Sentence
- ☐ Incarcerated-Sentenced
- ☐ Incarcerated-Unsentenced
- ☐ Protective Custody
- ☐ Probation/Parole
- ☐ Court ordered, observation & evaluation
- ☐ Court ordered for alcohol treatment
- ☐ Court ordered for mental health treatment
- ☐ None / No Involvement
- ☐ Other:

Number of times client attended a self-help program in the **30 days** preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/ mutual support groups focused on recovery from substance abuse and dependence:_______ Many times, or unknown

Annual Household income (please enter exact amount): $_________

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Household Composition: (who do you live with?)

☐ Client Lives Alone or Independently
☐ Client Lives with Children
☐ Client Lives with Non-Relatives
☐ Client Lives with Significant Other
☐ Client Lives with Relatives
☐ Client Lives with Adolescents
☐ Other: ____________________
☐ Client Lives with Significant Other & Children

Number of Children in Household? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Other
How many people live at your residence? (Including yourself) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Other

Primary Income Source:

☐ Alaska Native Corporation Dividends
☐ Supplemental Security Income-SSI
☐ Child Support
☐ Employment
☐ Interest and Other
☐ Spouse's or Significant Other's Income
☐ Retirement, Survivor, Disability Pensions
☐ Social Security
☐ Social Security Disability -SSDI
☐ Alimony
☐ SSI/SSDI Never
☐ SSI/SSDI Previous
☐ Parent's Income
☐ Public Assistance/Welfare Payments
☐ Railroad Retirement
☐ Alaska PFD
☐ Self-Employment
☐ Unemployment Compensation
☐ Tribal Assistance Program
☐ Other:

What is your Occupation?

☐ Accommodation & Food Services
☐ Administrative & Support Services
☐ Agriculture, Forestry, Fishing & Hunting
☐ Art, Entertainment, & Recreation
☐ Construction
☐ Educational Services
☐ Finance & Insurance
☐ Government
☐ Health Care & Social Assistance
☐ Information
☐ Management of Companies & Enterprises
☐ Manufacturing
☐ Mining, Quarrying, Oil & Gas Extraction
☐ Other Services (Except Public Admin.)
☐ Professional, Scientific & Technical Servs.
☐ Real Estate, Rental, & Leasing
☐ Retail Trade
☐ Self-Employed
☐ Transportation & Warehousing
☐ Utilities
☐ Wholesale Trade
☐ None

Do you currently use Tobacco?

☐ Cigarettes # of packs a day ________ ☐ Smokeless tobacco ☐ Cigars or pipes
☐ N/A- no tobacco use
Combination of more than one ☐

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Referral Source:

- ☐ Alcohol Detox or Residential Program
- ☐ Alaska Native Hospital
- ☐ Assisted Living Facility
- ☐ Alcohol Program
- ☐ API
- ☐ ASAP
- ☐ Attorney
- ☐ Court-Civil Proceedings
- ☐ Other Social/Community Agencies
- ☐ Correctional Agency (Probation Parole)
- ☐ Crisis/Respite Care
- ☐ Court-Criminal Proceedings
- ☐ of Corrections/Jail
- ☐
- ☐ Developmentally Disabled Program
- ☐ Developmental Disabilities Residential Program
- ☐ Division of Vocational Rehabilitation

- ☐ Drug Detox or Residential Program
- ☐ Federal Probation
- ☐ Halfway House
- ☐ Individual (including self-referral)
- ☐ Internal Referral
- ☐ Supervised Apartment
- ☐ Nursing Home/Immediate Care Facility
- ☐ Other CMHC Outpatient Caseload
- ☐ Office of Children Services
- ☐ Other MH, Not Psych; School, Church
- ☐ Other Residential/Institutional
- ☐ Partial Care or Day Care Program
- ☐ Private Psychiatric Hospital
- ☐ Psychiatrist /Psychiatric Outpatient
- ☐ Clinic
- ☐ Public Health (HS, PHS, Div Public Health)
- ☐ Community Health Center

- ☐ School
- ☐ SEARHC
- ☐ Self, Family or Friend
- ☐ Therapeutic Court
- ☐ Tribal Health Authority
- ☐ Tribal Health Facility
- ☐ Transitional Housing
- ☐ V.A. Hospital
- ☐ Village Health Aide
- ☐ Wellness Court
- ☐ Mental Health Court
- ☐ Physician Department
- ☐ Public Safety
- ☐ Drug Program
- ☐ Employer

Agency name and contact: You must furnish a release of information from this agency.

Name:____________________________

Agency:__________________________________Phone #:______________________________

Admission for: substance abuse, mental health, or both**:**__________
Number of arrests in the past **30 days?** __________________
Medication assisted treatment opioid therapy: ☐Yes ☐No

Substance abuse:

Primary:__________ Frequency:_________
Method:___________ At what age did you first use this substance?_______
Secondary: ________ Frequency: _______
Method:_________ At what age did you first use this substance? _______