AFS Behavioral Health Treatment Center (BHTC)
5851 E. Mayflower Crt. Wasilla, AK 99645
Phone: 907-376-4000 Fax: 907-373-1135

ADIS INTAKE INSTRUCTIONS & INFORMATION

1. **Complete & Return the packet**
   - Return by dropping off at our office, mail, or fax (information in the header)
     We strongly discourage returning packets via email as it is not a secure method of communication
2. **Pay $175 for Class**
   - We accept exact cash or card payments (card payments can be done over the phone ☺)
3. **Receive Materials for Class**
   - A book, pre-test, post-test, and course evaluation form will be given to you upon payment. All must be returned in order to receive a completion certificate.
   - A link for the class will be sent to your email address the Thursday prior to the class dates. Please check to see that you have that link before the weekend (our office is closed Saturdays & Sundays).

THIS PACKET INCLUDES:

☐ **Your confidentiality and service rights (2 pages)**
- Your health and/or substance use disorder information are protected under federal law [42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164]

☐ **Your demographic information**

☐ **An emergency contact release form**

☐ **Blank Consent Forms (x2)**
- **AFS cannot disclose your protected health information without your written consent** unless otherwise provided for by the regulations. The Consent Forms (aka: Releases of Information) included in this packet are so that you may provide your written consent for us to be able to speak with whomever we may need to treat you effectively, bill for your services, and/or help you complete any legal requirements. *It is generally recommended you fill one out for whomever referred you (if someone other than ASAP) and/or anyone who might be helping you through this process (ie. gives you rides, drops off/picks up paper work on your behalf, etc.)*

- Your substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

And please don't hesitate to reach out to us with any questions and/or concerns with completing this packet!
907-376-4000

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CLIENT RIGHTS & CONFIDENTIALIY

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PRIVACY RIGHTS

- Information regarding your health care, including payment for health care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. **Under these laws, Alaska Family Services (AFS) may not say to a person outside AFS that you attend the program, nor may AFS disclose any information identifying you as an alcohol or drug user, or disclose any other protected information except as permitted by federal law.**
- Generally, Alaska Family Services must obtain your written consent before it can share information about you for treatment, payment, and healthcare purposes. For example, AFS must obtain your written consent before it can disclose your health information to your insurance company in order to be paid for services.
- **However, federal law permits AFS to disclose information *without* your written permission in the following circumstances:**
  - To report a crime committed on AFS' premises or against AFS personnel;
  - Physical or sexual abuse or neglect committed against a child or elderly person
  - Pursuant to an agreement with a qualified service organization/ business associate;
  - For research, audit or evaluations;
  - To medical personnel in a medical emergency;
  - As allowed by an authorizing court order.
  - Suicidal or homicidal threats or attempts
  - Internal Communications

  It should be advised that information regarding the first two items is not protected
- **Before AFS can use or disclose any information about your health in a, manner which is not described above, we must first obtain your specific written consent allowing us to make the disclosure; such written consent may be revoked by you in writing at any time.**
  - The following require an individual's consent:
    - If applicable, most uses and disclosures of psychotherapy notes;
    - Uses and disclosures of protected health information for marketing purposes;
    - Disclosures that are sales of protected health information
  - If AFS intends to contact the individual for fundraising purposes, a notification of this intent and of the individual's right to opt out of receiving such communication
- **You have the right to:**
  - Request restrictions on certain uses and disclosures of your protected health information.
  - Receive confidential communications of your protected health information. You can request that we communicate with you by alternative means or at an alternative location. AFS will accommodate such requests that are reasonable and will not request an explanation from you.
  - Inspect and/or obtain a copy of your records maintained by AFS, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances.
  - Make amendments to your records maintained by AFS, with some exceptions. AFS may deny a client request for amendment if it determines that the information or record:
    - Was not created by an AFS employee
    - Is not part of a designated record set
    - Is accurate and complete
  - Receive an accounting of disclosures of your protected health information made by AFS during the six years prior to your request.
  - Obtain a paper and/or electronic copy of this notice.

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You can get more information on and/or begin the process for any of your rights with your primary clinician or by making contact with the AFS BHTC front desk

- AFS is required by law to maintain the privacy of protected health information, provide clients with notice of its legal duties and privacy practices regarding this information, and notify affected clients if unsecured protected health information is breached. **A violation of Part 2 is a reportable crime and that, under HIPAA, you may complain directly to AFS or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated** without fear of being retaliated against. A grievance form is available upon request at the BHTC front desk. Or you can reach out to the U.S. Department of Health and Human Services Office for Civil Rights (200 Independence Ave. S.W., Washington D.C. 20201 / 1-877-696-6775 / www.hhs.gov/ocr/privacy/hipaa/complaints/)

SERVICE RIGHTS

You have the right to:

- Right to be provided services that accommodate any visual, auditory, linguistic, and/or motor ability needs.
- Right to be informed about estimated expenses, manner & timing of payments, and consequences of nonpayment prior to service delivery.
- Right to participate in all service decisions.
- Right to be informed of the benefits, risks, side effects, and alternatives to planned services.
- Right to be offered the most appropriate and least restrictive or intrusive service alternative to meet your needs.
- Right to receive services in a manner that is free from harassment or coercion and that protects your right to self-determination.
- Right to refuse any service or treatment, unless mandated by law or court order.
- Right to be informed about the consequences of such refusal, which can include discharge.

AFS is required to abide by the terms of the notice that are currently in effect and reserves the right to change the terms of the notice and implement new notice provisions for all protected health information that it maintains. The new notice will be available upon request at the BHTC office. This notice became effective on: [June 2023]

For more information please contact the AFS BHTC at 907-376-4000
Administrative services can be received M-F from 8:00AM to 4:30PM. Program services can be received M-F from 8:00AM to 8:00PM. The AFSBHTC will try to accommodate your scheduling needs, within reason and pending staff availability.

I hereby acknowledge that I have reviewed this notice and understand that upon request I can receive a copy.

Client Signature	Date
Parent, guardian, or person authorized to sign for client	Date
Staff Signature	Date

☐I have read and signed this form but choose to decline a copy at this time. I'm aware I have the right to request a paper and/or electronic copy at any time.

ALASKA FAMILY SERVICES

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CLIENT PROFILE

First Name: _____ Last Name: _____ DOB [MM/DD/YYYY]: _____

Maiden Name: _____ Alternate Names: _____ SSN: _____

Sex: ☐Female ☐Male Medicaid #: _____

☐Other (specify): _____

Who referred you to our agency? _____

If Female, are you pregnant? ☐Yes ☐No Due Date: _____

Are you an injection drug user? ☐Yes ☐No Last time you injected? _____

CONTACT INFORMATION

Cell Phone Number: _____ Can we leave voicemails? ☐Yes ☐No

Alternate Phone Number: _____ Can we leave voicemails? ☐Yes ☐No

Email Address: _____

Physical Address: _____

City _____ State _____ Zip _____

Mailing Address: _____

City _____ State _____ Zip _____

ADDITIONAL INFORMATION

What is your Ethnicity?

☐NOT Spanish/Hispanic/Latino Mexican	☐ Cuban	☐ Hispanic (specific origin not specified)
☐Mexican American	☐ Chicano/Other Hispanic	
☐ Puerto Rican	☐ Spanish/Hispanic Latino	

What is your Race?

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

Veteran Status: ☐Yes ☐No ☐Other (specify): _____

Highest level of education you've completed? _____

Any language barriers and/or preferences? (an interpreter service can be provided)

Any special needs you would like us to be aware of?

Are you currently receiving mental health and/or substance use treatment services from any other agency? ☐Yes ☐No

If yes, which agency and what type of services?

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EMERGENCY CONTACT RELEASE

For your safety the following information will be kept in your file, accessible only to BHTC staff members, in the event you experience a medical emergency while receiving services.

I, _____
[Client Name Printed]

Hereby give my consent to be given emergency medical treatment in the event of an accident, injury, or illness.

I hereby release Alaska Family Services and its representatives from any liability rising from an emergency situation in which it is deemed necessary to pursue medical treatment.

In case of an emergency, Alaska Family Services may contact:

1. _____ _____ _____
Emergency Contact Name | Relationship to Client | Phone #

2. _____ _____ _____
Emergency Contact Name | Relationship to Client | Phone #

Drug Allergies:	
Medications:	
Other medical conditions we should be aware of?	
Insurance Information or Medicaid #:	

By signing below I authorize disclosure of the above information to appropriate emergency personnel.

_____ _____
Client Signature | Date

_____ _____
Parent, guardian, or person authorized to sign for client | Date

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CONSENT FORM

I, _____ **authorize:** **Alaska Family Services (AFS) / Behavioral Health Treatment Center (BHTC)**
[Client Name Printed] [name of general designation of individual or entity making the disclosure]
Phone: 907-376-4000 Fax: 907-373-1135
Address: 5851 East Mayflower Court, Wasilla, AK 99654

To ☐**Release information to:** ☐**Obtain information from:** _____
[name of individual(s) or entity(ies) who will receive the information]
Phone: _____ Fax: _____
Address: _____

Information to be exchanged: [describe how much and what kind of information may be disclosed, should be as limited as possible]
☐My name & other personal identifying information ☐My status as a patient in alcohol and/or drug treatment
☐Assessment/Intake Summary ☐Treatment Plan/Case Plan
☐Discharge Summary ☐UA Results
☐Attendance ☐Financial Information
☐Paperwork to be dropped off/picked up ☐Other: _____

For the purpose of: [describe the purpose of the disclosure; should be as specific as possible]
☐Legal Request ☐Enable inquiries about and/or provide information on my financial account
☐Coordination of Care ☐Further Treatment ☐Other: _____

Communication Permitted Via: ☐Verbally ☐Electronically or ☐In Writing

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. **Unless I revoke my consent earlier, this consent will expire automatically as follows:**
☐90 days after discharge, OR
☐Other Terms _____
[Other date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

*I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
*I understand that generally Alaska Family Services may not condition my treatment on whether I sign a consent form but I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.
*By my signature below I indicate that I have read this document (or have had it read to me), that I fully understand its meaning, that I consent to its terms knowingly and voluntarily, and that I have not been under any undue duress or influence nor under the influence of alcohol or drugs in making this agreement.

_____ _____ Client DOB: _____
Client Signature Date Phone Number: _____

_____ _____
Parent, guardian, or person authorized to sign for client Date

_____ _____
Staff Signature Date

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at § § 2.12(c)(5) and 2.65.

This authorization is revoked: _____ Date: _____

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☐Paperwork to be dropped off/picked up
☐My status as a patient in alcohol and/or drug treatment
☐Treatment Plan/Case Plan
☐UA Results
☐Financial Information
☐Other: _____

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