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

INTAKE PACKET 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
   - Please bring:
     - Medicaid/Private Insurance cards (or provide copies of front/back of card)
     - Proof of income in order to see if you qualify for our sliding fee scale (can include W-2s, last 2 pay stubs, tax return, workman's comp, social security income, retirement pension, disability income, public assistance, native dividends, etc.)
       If you do not provide adequate proof of income you will be charged at the full rate
2. **Clinician reviews screening tools from the intake packet**
   - This determines your assessment type, fee amount, and when we can get you scheduled
3. **Pay for Assessment** (unless you have Medicaid)
   - We accept exact cash or card payments (card payments can be done over the phone ☺)
4. **Appointment Scheduled**
   - Appointments can be done in-person or via telehealth (i.e. Zoom)

<u>THIS PACKET INCLUDES:</u>

☐ **Screening Tools (5 pages)**
- Use 'N/A' or '0' for questions that do not apply to you and complete the packet as thoroughly as possible.
- The sooner you get your screening tools to us, the sooner we can have your assessment fee and/or possible appointment slot figured out.

☐ **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 (3 pages)**

☐ **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 (see the Client Rights page for more information). 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), any other behavioral health entity you're receiving services from, 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.).*

☐ **A Multiple Consent Form for Insurance Coverage & Reimbursement**
- Even if you have Medicaid, please list any private insurance you may also be covered under (required for Medicaid billing purposes).
- Please note we are not a preferred provider for any insurance company and your insurance company may or may not cover mental health and/or substance use services. We are absolutely willing to help you figure that out but for this reason we do have to collect your full assessment fee up front in order to schedule the assessment.
- Millennium Health is the company we use for urinary analysis/toxicology testing. If you are seeking any services involving alcohol/substance use it is recommended that you sign for them ahead of time. We will not release any of your information to them unless you are recommended to AND agree to do substance use treatment through AFS.

☐ **A Consent Form for Cornerstone Credit LCC for Debt Collection**
- Cornerstone is the collections company we contract with if you fail to make agreed upon payments for your services and/or fail to remain in communication with us regarding your payments.

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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ALASKA SCREENING TOOL (AST)

Client Name: _____ **Client Phone Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days):	**0-14 days**
1. Over the last two weeks, how many days have you felt little interest of pleasure doing things?.....	
2. How many days have you felt down, depressed, or hopeless?.....	
3. Had trouble falling asleep or staying asleep or sleeping too much?.....	
4. Felt tired or had little energy?.....	
5. Had poor appetite or ate too much?.....	
6. Felt bad about yourself or that you were a failure or had let yourself or your family down?.....	
7. Had trouble concentrating on things, such as reading the newspaper or watching TV?.....	
8. Moved or spoken so slowly that other people could have noticed?.....	
9. Been so fidgety or restless that you were moving around a lot more than usual?.....	
10. Remembered things that were extremely unpleasant?.....	
11. Were barely able to control your anger?.....	
12. Felt numb, detached, or disconnected?.....	
13. Felt distant or cut off from other people?.....	

SECTION II – Please check the answer to the following questions based **on your lifetime**.		
14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe……..	☐Yes	☐No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs……	☐Yes	☐No
16. I have lived with someone who was seriously depressed or seriously mentally ill……...	☐Yes	☐No
17. I have lived with someone who attempted suicide or completed suicide……..	☐Yes	☐No
18. I have lived with someone who was sent to prison……	☐Yes	☐No
19. I, or a close family member, was placed in foster care……..	☐Yes	☐No
20. I have lived with someone while they were physically mistreated or seriously threatened……..	☐Yes	☐No
21. I have been physically mistreated or seriously threatened…….	☐Yes	☐No
a. If you answered **"Yes"**, did this involved your intimate partner (spouse, girlfriend, or boyfriend)?.....	☐Yes	☐No

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ALASKA SCREENING TOOL (AST) CONTINUED

SECTION III – Please answer the following questions based **on your lifetime**. (D/N = Don't Know)

22. I have had a blow to the head that was severed enough to make me lose consciousness..	☐Yes	☐No	☐D/N
23. I have had a blow to the head that was severe enough to cause a concussion……..	☐Yes	☐No	☐D/N
If you answered "Yes" to 22 or 23, please answer a-c:			
a. Did you receive treatment for the head injury?.....	☐Yes	☐No	
b. After the head injury, was there permanent change in anything?.....	☐Yes	☐No	☐D/N
c. Did you receive treatment for anything that changed?.....	☐Yes	☐No	
24. Did your mother ever consume alcohol?.....	☐Yes	☐No	☐D/N
a. **If Yes**, did she continue to drink during her pregnancy with you?.....	☐Yes	☐No	☐D/N

SECTION IV – Please answer the following questions based on the **past 12 months**.

25. Have you had a major life change like death of a loved one, moving, or loss of a job?.....	☐Yes	☐No
26. Do you sometimes feel afraid, panicky, nervous or scared?.....	☐Yes	☐No
27. Do you often find yourself in situations where your heart pounds and you fell anxious and want to get away?.....	☐Yes	☐No
28. Have you tried to hurt yourself or commit suicide?.....	☐Yes	☐No
29. Have you destroyed property or set a fire that caused damage?.....	☐Yes	☐No
30. Have you physically harmed or threatened to harm an animal or person on purpose?.....	☐Yes	☐No
31. Do you ever hear voices or see things that other people tell you they don't see or hear?.....	☐Yes	☐No
32. Do you think people are out to get you and you have to watch your step?.....	☐Yes	☐No

SECTION V – Please answer the following questions based on the **past 12 months**.

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants?.....	☐Yes	☐No
34. Have you missed school or work because of using alcohol, drugs, or inhalants?.....	☐Yes	☐No
35. In the past year have you ever had 6 or more drinks at any one time?.....	☐Yes	☐No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much?..	☐Yes	☐No
37. Do you think you might have a problem with alcohol, drugs, or inhalant use?.....	☐Yes	☐No

THANK YOU for providing this information! Your answers are important to help us serve you better.

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PC-PTSD-5 **ID#:**

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- A serious accident or fire
- A physical or sexual assault or abuse
- An earthquake or flood
- A war
- Seeing someone be killed or seriously injured
- Having a loved one die through homicide or suicide

Have you ever experienced this kind of event?

☐Yes ☐No

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you:

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to? ☐Yes ☐No
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? ☐Yes ☐No
3. Been constantly on guard, watchful, or easily startled? ☐Yes ☐No
4. Felt numb or detached from people, activities, or your surroundings? ☐Yes ☐No
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ☐Yes ☐No

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SIMPLE SCREENING INSTRUMENT FOR ALCOHOL & OTHER DRUGS (SSI-AOD)

During the past 6 months:

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin, or other opiates, uppers, downers, hallucinogens, or inhalants)…….. ☐Yes ☐No
2. Have you felt that you too much alcohol or other drugs?..... ☐Yes ☐No
3. Have you tried to cut down or quit drinking or using drugs?..... ☐Yes ☐No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program).. ☐Yes ☐No
5. Have you had any of the following?
   Put a check mark next to any problems you have experienced.
   - ☐ Blackouts or other periods of memory loss?
   - ☐ Injury to your head after drinking or using drugs?
   - ☐ Convulsions or delirium tremens (DTs)?
   - ☐ Hepatitis or other liver problems?
   - ☐ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   - ☐ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ☐ Injury after drinking or using?
   - ☐ Used needles to shoot drugs?

Check "yes" if at least one of the eight items above is checked……..... ☐Yes ☐No

6. Has drinking or other drug use caused problems between you and your family or friends?..... ☐Yes ☐No
7. Has your drinking or other drug use caused problems at school or work?..... ☐Yes ☐No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession)…… ☐Yes ☐No
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ☐Yes ☐No
10. Do you need to drink or use drugs more and more to get the effect you want?..... ☐Yes ☐No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?..... ☐Yes ☐No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?..... ☐Yes ☐No
13. Do you feel bad or guilty about your drinking or drug use?..... ☐Yes ☐No

The next questions are about lifetime experiences.

14. Have you ever had a drinking or other drug problem?..... ☐Yes ☐No
15. Have any of your family members ever had a drinking or drug problem?..... ☐Yes ☐No
16. Do you feel that you have a drinking or drug problem now?..... ☐Yes ☐No

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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.

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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ALCOHOL & DRUG HISTORY

Mark 'N/A in first column if you have never used the listed substance

Drug	Age at 1st Use	Age at Regular Use	Age at Heaviest Use	Heaviest Use Frequency Amounts	Past 12 Mo. Frequency Amounts	# of Days Used in Last 30 Days	Date of Last Use	Method of Use (oral, smoked, injected, snorted)
Alcohol								
Amphetamine (Adderall, Dexedrine, Concerta, Ritalin, diet drugs)								
Caffeine								
Cannabis (Marijuana, Hashish)								
Cocaine/Crack								
Hallucinogens (MDMA/Ecstasy, Ketamine, LSD, mushrooms)								
Inhalants ("whippets", gasoline, glue, paint, Dust-Off, hair spray, nitrous oxide)								
Methamphetamine ("Crank", "Crystal", "Ice")								
Nicotine								
Opioids (Heroin, Methadone, Morphine, Opium, Oxycodone, Hydrocodone, Codeine)								
Phencyclidine (PCP, Angel Dust)								
Sedatives or Anxiolytic (Valium, Xanax, Klonopin, Ativan, Rohypnol, GHB)								
Synthetic Drugs								
Over the Counter Drugs (DXM, "Skittles", cough medications, No-Doz, sleep aids, Benadryl, Dramamine)								
Prescription Drugs (any drugs you have been prescribed)								
Other Drugs (Steroids, Salvia)								

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FINANCIAL INFORMATION

Annual Household Income: [*Approximate or exact numeric amount and include Alaska's PFDs if applicable]*

$

Employment Status	Primary Source of Income	Health Insurance	Primary Payment Source
☐ None	☐ None	☐ None	☐ Client Self Pay
☐ Employed/Full Time	☐ Employment	☐ Commercial	☐ Medicaid
☐ Employed/Part Time	☐ Alaska PFD	☐ Medicaid	☐ Medicare
☐ Homemaker	☐ Public Assistance/Welfare	☐ Medicare	☐ Sliding Scale/partial payment
☐ Seasonal/In Season	☐ Significant Other's Income	☐ Private Insurance	☐ Blue Cross/Blue Shield
☐ Seasonal/Out Season	☐ Parent's Income	☐ VA Insurance	☐ Aetna
☐ Retired	☐ Retirement/Surv./Disability ☐ Pension	☐ Health Maint. Or. (HMC)	☐ CIGNA
☐ Disabled	☐ Social Security Disability (SSDI)	☐ Indian Health Service	☐ HMO
☐ Unemployed/seeking work	☐ Supplemental Security Insurance (SSI)	☐ Other:	☐ AK Native Health Care
☐ Unemployed/not seeking work	☐ Unemployment Compensation		☐ Indian Health Services
☐ Unemployed/subsistence	☐ Tribal Assistance Programs		☐ No Charge
☐ Student	☐ Alaska Native Corp Dividends		☐ Other:
☐ Resident/Inmate	☐ Alimony		
☐ Other:	☐ Child Support		
	☐ Other:		

HOUSEHOLD INFORMATION

Living Arrangement		Marital Status
☐ Private Residence w/out supportive services	☐ Correction/Detention Facility	☐ Never Married/Single
☐ Private Residence with supportive services	☐ Group Home	☐ Married
☐ Shelter	☐ Foster Home	☐ Cohabitating
☐ Transitional Housing	☐ Therapeutic Foster Home	☐ Separated
☐ Halfway House	☐ Nursing Home	☐ Divorced
☐ Homeless	☐ Assisted Living Facility	☐ Widowed
☐ Crisis Residence	☐ Hospital for non-psychiatric purposes	
☐ Residential Treatment Facility	☐ Hospital for psychiatric purposes	

Number of Children Living in the Home

I hereby declare that the information I provided in this Intake Form is true and correct. I also understand I am to update and correct any of the information with the BHTC staff in the event that there are changes.

Client Signature _____ Date _____

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

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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
☐Assessment/Intake Summary
☐Discharge Summary
☐Attendance
☐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: _____

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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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
☐Assessment/Intake Summary
☐Discharge Summary
☐Attendance
☐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: _____

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: _____

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

INSURANCE COVERAGE & REIMBURSEMENT 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]
Address: 1825 South Chugach Street, Palmer, AK 99645

To exchange verbal, written, and electronic information with:
[Check the box for each entity you are authorizing AFS/BHTC to communicate with]

☐ **Medicaid**
Optum Alaska [PO Box 30760, Salt Lake City, UT 84130]
& State of Alaska DHSS Division of Behavioral Health [PO Box 110607, Juneau, AK 99811]

☐ **Millennium Health –** Toxicology Company [16981 VIA Tazon, San Diego, CA 92127]

☐ **Primary Insurance Carrier**: _____
Insurance Carrier's Address: _____
Primary Policy Holder Info:
Name: _____ SSN: _____ Gender: _____
DOB: _____ Address: _____

☐ **Secondary Insurance Carrier**: _____
Insurance Carrier's Address: _____
Secondary Policy Holder Info:
Name: _____ SSN: _____ Gender: _____
DOB: _____ Address: _____

Information to be exchanged: [All are required if you would like either Medicaid and/or your insurance billed for our services]

☐My name and other personal identifying information
☐My status as a patient in alcohol and/or drug treatment
☐Summary of treatment plan, progress, and compliance
☐Assessment results & history
☐ Date of Admission
☐ Attendance
☐ Date of Discharge
☐ Discharge Plan
☐ Urinalysis Results
☐ Initial Evaluation
☐ Diagnosis

For the purpose of:
☐Enabling the agencies listed above to evaluate my claims for insurance coverage and reimbursement.

*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 also 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:**

- **The date on which my insurance claims for this course of alcohol or drug abuse treatment have been completely processed.**

*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.

_____ _____ 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).

This authorization is revoked: _____ Date: _____

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

COLLECTIONS CONSENT FORM

I, _____ **authorize:** **Alaska Family Services (AFS) / Behavioral Health Treatment Center (BHTC)**
[Client Name Printed]

Address: 1825 South Chugach Street, Palmer, AK 99645

To exchange verbal, written, and electronic information with:

☐**Cornerstone Credit LLC** [PO Box 92090, Anchorage, AK 99509]

Information to be exchanged:

☐My name and other personal identifying information
☐Financial Information

For the purpose of:

☐Collection of debt

*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 also 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:**

- **The date on which my financial account is paid in full.**

*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.

_____ _____ 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).

This authorization is revoked: _____ Date: _____