Set Free Alaska's Children's Program

Parent and/or Legal Guardian

Application

This packet is made to be printed double sided.

Please make sure to complete the packet in its entirety. Before files can be reviewed, we will also need any pertinent collateral or court documents supporting legal guardianship, if applicable.

If your packet is incomplete, we will not be able to review your application.

Please be sure to complete all documents.

1. AKAIMS Minimal Data Set Forms: Client Intake Form (*make sure to complete this form)*
2. Behavioral Health Intake Form
3. Infectious Disease Form *(if the child is above the age of 12)*
4. Emergency Contact Information
5. Consent to Treatment for a Minor
6. Understanding Set Free Alaska's Children's Program Wait List Policy Signature page
7. Client Financial Responsibility Agreement
8. Telehealth Consent
9. ROI Section
10. Release of Information for the parent(s), legal guardian(s)
11. Disclosure of Information *(if there is substance use)*

If you have any questions, please contact our office 907.373.4732.

When you have completed your child's packet please scan and email it to office@setfreealaska.org or drop it off in person at our office.

Thank you.

AKAIMS MINIMAL DATA SET FORMS
CLIENT INTAKE FORM

Entry of this form in the AKAIMS establishes the individual as a client. Fill in the blanks or check the boxes for each question. Do not leave anything blank. These are all required fields ("minimal data set") for the State of Alaska and continued funding is contingent upon compliance with this state requirement.

Client Profile

1. **Child Name (First and Last)** _____

   IF FEMALE MAIDEN NAME IS REQUIRED _____

   Name preferred to be called if different than listed:_____

2. **Client Gender:** **Female** **OR** **Male**

3. **Parent/Foster Parent Name and Number:** _____

4. **Mailing Address: Street, Apartment** _____

   City, State, Zip _____

5. **Physical Address: Street, Apartment** _____

   City, State, Zip _____

6. **Phone Number(s):** _____

7. **Child Date of Birth:** _____

8. **Child Social Security Number:** __ __ __ -- __ __--__ __ __ __

9. **Child Medicaid ID Number:** _____

10. **List of persons not allowed to have contact with child:**

_____

_____

Demographics

Race(s): *CHECK ALL THAT APPLY*		***Ethnicity:*** *CHECK ALL THAT APPLY*	***English Fluency:*** *CHECK ONE*
☐ American Indian	☐ Aleut	☐ **Not Spanish/Hispanic/Latino**	☐ Excellent
☐ Asian	☐ Athabascan	☐ Chicano	☐ Good
☐ Black/African American	☐ Haida	☐ Cuban	☐ Moderate
☐ Caucasian	☐ Inupiat	☐ Hispanic	☐ Poor
☐ Native Hawaiian	☐ Tlingit	☐ Mexican American	☐ Not at all
☐ Pacific Islander	☐ Tsimshian	☐ Puerto Rican	
☐ Other	☐ Yupik	☐ Spanish/Hispanic/Latino	
	☐ Other Alaskan Native		

Special Needs: *CHECK ALL THAT APPLY*		***Education:*** *HIGHEST LEVEL COMPLETED*
☐ None	☐ Moderate to Severe Medical Problems	☐ **High School Diploma**
☐ No Response	☐ Severe Hearing Loss or Deaf	☐ **GED**
☐ Dev. Disabled	☐ Visual Impairment or Blind	☐ **K – 12**
☐ Major Difficulty	☐ Other	**Highest Grade Completed:** _____
		☐ **Special Education/Ungraded Classes**

INTAKE INFORMATION

1. ***Today's Date:*** __ __/__ __/ __ __

2. ***Initial Contact:*** CHECK ONE

☐ Phone ☐ Drop In ☐ Other ☐ By Appointment

3. ***City of Residence:*** CHECK ONE

☐ Anchorage ☐ Big Lake ☐ Eagle River ☐ Houston ☐ Palmer ☐ Wasilla ☐ Other: _____

4. ***Referral Source:***

☐ ASAP	☐ Private Psychiatric Hospital
☐ Alaska Native Hospital	☐ Psychiatrist or Psychiatric Outpatient Clinic
☐ Church	☐ Public Health
☐ Individual/Self-Referral	☐ School
☐ JASAP	☐ Social Services
☐ Juvenile Justice	☐ Social/Community Agency
☐ Office of Children's Services	☐ Therapeutic Court
☐ Other	☐ Youth Court
☐ Physician	

5. ***Injection Drug User (In Past 12 Months):*** CIRCLE ONE **YES** OR **NO**

6. Please indicate up to 3 presenting problems with number 1 being primary:

Alcohol _____	Financial _____
Alcohol & Drugs _____	Poverty _____
Child Abuse Victim _____	Runaway Behavior _____
Coping with Daily Roles/Activities _____	Sexual Abuse Victim _____
Depression _____	Social/Interpersonal _____
Drugs _____	Suicide Attempt/Threat _____
Eating Disorder _____	Thought Disorder _____

7. ***Presenting Problem(s) in clients own words (Why are you seeking our services?):***

_____

_____

_____

9. ***Required if Female:*** Pregnant: **YES** OR **NO** **If yes: DUE DATE __ __/ __ __ / __ __**

How did you hear about us? (Please circle one of the following)

TV **Radio** **Newspaper** **Referral from friend/agency** **Other**

Set Free Alaska
Behavioral Health Intake Form
Child and Adolescent Outpatient Program

History of Presenting Problem

Child's Name: _____ DOB: _____ Age ____

Form completed by: ___ Parent ___ Foster Parent ___Guardian ___ Other: _____

Referred by: ___ Parent/Guardian ___ OCS ___ The Children's Place ___ Doctor
___ Other _____

Child's primary reason for needing help at this time.

_____
_____

How long has your child had these symptoms, problems or issues?

_____
_____

Has your child received treatment for these issues in the past? ___ Yes ___ No
If yes, when was the last time they were in treatment and who were they receiving treatment from?

_____
_____

Has your child ever had inpatient mental health treatment? ___ Yes ___ No
If yes, please give a brief description of treatment dates, facility name and outcomes.

_____
_____

Describe the impact your child's current behavioral/emotional struggles are having on the family.

_____
_____

Describe your child's unique qualities and strengths.

_____
_____

Is there any current legal involvement that may have an impact on your child? Please check all that apply:

_____ Custody _____ Adoption _____Probation _____ Visitation _____ Child Protective Services

_____ Other

If yes, briefly describe:

_____
_____

Behavior Checklist Please check all that apply within the past six months

Behavior	X	Behavior	X
Crying, sadness, depression		Hallucinations	
Verbalizing a wish to die		Strange or unusual behavior	
Isolation/Withdrawal		Low motivation	
Worries more than others		Twitches or unusual movements	
Nightmares, night terrors		Wanting to run away	
Bedtime fears		Sneaks out at night	
Bed wetting		Self-injuries	
Soiling (pooping) in pants		Self-induced vomiting	
Sleep difficulties, too much or too little		Binge eating	
Hyperactivity		Self-starvation	
Frequently acts without thinking		Blames others for own mistakes	
Does not finish things		Stealing	
Easily distracted		Lying	
Often caught daydreaming		Hurts animals	
Has habits or rituals		Destroys property	
Temper outbursts		Hurts people	
Irritability		Drug use	
Frequent arguing		Alcohol use	
Does things to annoy others		Tobacco use	
Anxious/Nervous		Problems with authority	
Unusual fears or phobias		Sexual Problems	

Developmental History

During pregnancy, did mother:

_____ Drink _____ Drugs _____Illness _____Accident _____Victim of Domestic Violence

_____ Pregnancy Related Problems _____ Complications with Labor/Delivery

If yes, please describe

_____

_____

Did child meet all of their developmental milestones on time?

_____ Sitting Up _____Crawling _____Walking _____Feeding Self _____Toilet Training _____Talking

_____ Dressing Self _____Sleeping Through the Night

Briefly explain any delays:

_____

_____

Medical History

Is your child currently under the care of a physician or psychiatrist? ___ Yes ___No

If yes: Doctor's Name: _____ Phone Number: _____

Treatment for: _____

Is your child currently taking any medications? ___ Yes ___No If yes, include the following information:

Names of Medications	Dosage	Prescribed by

Please indicate if your child has had any of the following: Check and describe

X	Condition	Age	Description
	Major Illness		
	Serious Infection		
	Head Injury		
	Hospitalization		
	Surgeries		
	Ear Infection		
	Poisoning		
	Allergies		
	Asthma		
	Vision Impairment (glasses or contacts)		
	Hearing		

Does your child have any other medical conditions? ___ Yes ___ No
If yes, please explain:

Are your child's immunizations up to date? ___ Yes ___ No

Does your child frequently complain of body aches and pains? ___ Yes ___No

If yes, please describe:

Does your child miss school because of his/her physical complaints? ___Yes ___No

If yes, please describe:

Interpersonal Relationships Check each item that describes your child:

	Yes	No		Yes	No
Is shy			Fights with others		
Prefers to be alone			Is demanding/bossy		
Has many friends			Bullies others		
Has a few friends			Plays with kids their own age		
Is picked on a lot			Conflicts with parents/guardian		
Is often alone, but desires friends			Poor peer relationships		
Respect for authority			Excessive conflicts with siblings		

Education

Where does your child attend school? _____

Does your child have an Individualized Learning Plan (IEP)? _____

Has your child repeated a grade? ___ yes ___ No

Does your child often get discipline referrals, or detention? ___ Yes ___No

Has your child been suspended this school year? ___ yes ___No

Family Life

Please list all of the people who currently live with your child

Name	Age	Relationship

What are your family supports? (friends, church etc.)

_____

_____

What are your family strengths?

_____

_____

Forms of discipline used in the home: _____ Time Out _____ Incentives/Rewards _____ Grounding

_____ Loss of Privileges _____ Extra Chores _____Physical/corporal punishment

Other: _____

Please list any family history of mental illness.

_____

_____

_____

Current Family Stressors Check all that apply:

Family Stressor	**X**	Family Stressor	**X**
Financial problems		Legal issues	
Divorce		Death of a relative	
Job loss		Death of a friend	
Parents using drugs/alcohol		Family illness	
Housing problems		Custody disputes	

Please list any other stressors not mentioned above.

_____

_____

_____

SET FREE ALASKA
PO Box 876741
Wasilla, AK 99687

Infectious Disease Risk Assessment

The following questions are necessary to assess your risk for infectious diseases. You are not required to answer these questions to participate in an assessment/treatment and client confidentiality laws protect all answers.

Client Name: _____ Client #: _____

Infectious Disease Risk	Yes	No	?
Have you seen a health care provider in the past three months			
Do you or have you lived on the street or in a shelter			
Have you ever been in jail/prison/juvenile detention			
Have you ever been in a long-term care facility (mental health hosp, nursing home, rehab)			
In the past 3 months, have you traveled outside the US (where:_____)			
Are you a combat veteran			
In the past year, have you had a tattoo, body piercing, acupuncture, or contact with blood			
Where were you born			
How long have you been in the US			
Have you lived with anyone diagnosed with TB in the past year			
Have you ever been treated for TB			
Have you ever been told you have Hepatitis A			
Have you ever been told you have Hepatitis B			
Have you ever been told you have Hepatitis C			
Have you ever used needles to shoot drugs			
Have you ever shared needles or syringes to inject drugs			
Have you ever had a job where you were at risk for needle sticks or blood contact			
In the past year, have you or anyone you had sex with have an STD or Hepatitis			
In the past 30 days have you had any of these symptoms lasting more than 2 wks			
Nausea			
Fever			
Drenching night sweats that were so bad you had to change clothes or bed sheets			
Productive cough			
Coughing up blood			
Shortness of breath			
Lumps or swollen glands in the neck or armpits			
Loss of weight without trying to			
Diarrhea lasting more than a week			
Brown tinged urine			
Women: Missed periods for last two months			

Extreme fatigue			
Jaundice or yellow eyes			
HIV/AIDS/Hepatitis C Risk	**Yes**	**No**	**?**
Did you receive a blood transfusion before 1992			
Have you received blood products produced before 1987 for clotting problems			
Was your birth mother infected by Hepatitis C during the time of your birth			
Have you been or are you currently on long-term kidney dialysis			
Have you had unprotected sex with someone who has the blood disease hemophilia			
Have you had unprotected sex with a person who injects drugs			
Have you had unprotected sex with a man who has sex with other men			
Have you had sex in exchange for money or drugs in order to survive			
Have you had unprotected sex with more than one partner in the past 6 months			
Have you had sex or shared needles with a person who has AIDS, HIV+, or Hep C +			
Have you ever injected drugs, even once			
Have you ever been pricked by a needle that may have been infected with HIV or Hep C			
Have you ever had a blood test for HIV			
If no, would you like to be tested			
If yes, was it within the last six months			
Have you ever had a blood test for Hepatitis C			
If no, would you like to be tested			
If yes, was it within the last six months			
How would you judge your own risk for being infected with HIV (Please circle one)			
I know I am infected			
I think I am at high risk			
I think I am at low risk			
I think I am at **NO** risk			
I am not sure what my risk is			
How would you judge your own risk for being infected with Hepatitis C (Please circle one)			
I know I am infected			
I think I am at high risk			
I think I am at low risk			
I think I am at **NO** risk			
I am not sure what my risk is			

Client completed / did not complete the risk assessment. If completed, client was / wasn't referred to the health department or a primary care physician. (circle correct responses)

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

Emergency Contact Information

Client Name: _____

Mailing Address: _____

Physical Address:_____

Phone# _____ Cell#_____

In case of emergency Set Free Alaska Staff have my permission to notify any of the following persons':

Name: _____

Phone# _____ Cell#_____

Relationship: _____

Name: _____

Phone# _____ Cell#_____

Relationship: _____

Name: _____

Phone# _____ Cell#_____

Relationship: _____

Primary Physician:_____

Office or Business Name: _____

Address: _____

Phone# _____

By signing this I understand that I am giving Set Free Alaska permission to contact any of the persons whom I have listed above in case of an emergency

_____	_____	_____
Client Signature	Client Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Printed Name	Date

Children's Program Information

About the Therapy Process

Before starting therapy, it is necessary to understand that the therapeutic process has both benefits and risks. The very nature of therapy often involves discussing and dealing with difficult events and upsetting issues. As a result, some people may experience uncomfortable feelings such as, fear, sadness or loneliness. Additionally, there may be an increase in problem behaviors. However, research supports the benefits of therapy to both children and adolescents. While there are no guarantees about the outcomes of therapy, children and adolescents can experience a reduction in problem behaviors, increased emotional well-being and improved closeness and communication within their interpersonal relationships. During the therapeutic process the therapist will utilize individual child therapy, family therapy, social skill building, cognitive behavioral therapy, client centered therapy, and other forms of talk therapy. Additionally, the therapist will draw from aspects of both play therapy and various other expressive arts therapy.

Confidentiality

The confidentiality of all counseling interactions is protected by law. Anything you tell your therapist is considered privileged information and will be held in confidence by the therapist. Information will not be released about you to others unless you give the therapist permission to do so in writing, by signing a release of information form. There are times in which laws and professional codes of ethics require the therapist break confidentiality such instances include:

•Medical emergencies
•The existence of a threat of danger to self or others
•Reasonable suspicion of current child abuse, abandonment or neglect, dependent adult or elder abuse
•A court order or where otherwise legally required
•Third party billing claims requirements
•Receipt of a properly executed consent form

Parents are encouraged to respect their minor child's right to confidentiality, in order to help the minor to feel safe and to build a trusting relationship with the therapist. Parents should be informed that in working with children/adolescents special care and sensitivity will be given to such topics as substance abuse and sexuality. The therapist may encourage the child/adolescent to share critical information and will help them to do this, with their parent/guardian, but we will not do so ourselves unless it is necessary to protect the wellbeing or life of the minor child or someone else.

**Please email or call 24 hours before the session, if you have information you want the therapist to be aware of so that she/he has time to receive the information and plan the session accordingly.*

Custody/Guardianship

•Consent for services can only be authorized by the current legal guardian. For divorced, or legally separated parents' consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement).

•In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts).
•As a general guideline, Set Free Clinicians will not make recommendations to the court concerning parenting issues or custody.

Client Rights (Please see Notice of Privacy Practices for procedure)
•You have the right to ask questions, refuse certain therapeutic techniques. You also have the right the right to be advised of the consequences of such refusal or withdrawal.
• You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. If you wish, Set Free will provide you with the names of other qualified therapists.
• You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.
• Parents have the legal right to request medical and billing records. Therapeutic treatment notes are protected by law and will not be released as a part of the treatment record.

This is for your records. We do not need these pages back.

Consent to Treatment for a Minor

• I acknowledge that I have received, read (or have read to me), and understand the information provided to me about the therapy I am considering for my child. I have had all my questions answered fully.

• I do herby consent to allow my child _____ to take part in psychotherapy with a Set Free Alaska, Clinician. I understand that a treatment plan will be developed with the therapist and a regular review of progress toward meeting the treatment goals will occur.

• I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

• I confirm that I have the legal right to consent to my child's mental health treatment without the consent of any other individuals.

• I am aware that as the parent or legal guardian I may stop treatment with the therapist at any time. The financial obligation for the services received shall fall under the responsibility of the parent who is initially seeking treatment.

• I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers or any services or treatments my child receives.

• I understand that I must call to cancel an appointment for my child at least 24 hours in advance. I acknowledge that continually showing up more than 15 minutes late for appointments or ongoing no-shows may result in my child being discharged from therapeutic services.

• I understand that the agency does not use seclusion and restraint as part of their nonviolence prevention program.

• I agree not to carry or to knowingly allow my child to carry any weapons, drugs, or drug paraphernalia within the Set Free Alaska facility.

• I understand that Set Free does not administer, maintain, or control my child's prescription medication in any manner.

• I understand that my child will participate in emergency preparedness drills as a part of the agencies health and safety program.

• I understand that in the event of an emergency the Set Free Alaska staff, as well as interns will direct my child in the necessary actions to be taken.

• I understand that Set Free utilizes a multi-disciplinary approach and therefore aspects of my child's treatment, and diagnosis will be discussed in treatment team meetings and with the clinical staff.

• I understand that the information the therapist gains from working with my child is confidential. With the child's permission the therapist will share information that they believe is important with his/hers parent or guardian.

• I understand that the therapist will not give information to anyone else without my written authorization, unless the situation is a mandatory reporting situation or if a court order is receviced.

• I understand, as the parent(s) not to request any information for court related reason whatsoever, including but not limited to custody issues.

• I understand that the role of the therapist is not to make recommendations to the judge or to express opinions concerning divorce or custody issues.

• I agree to submit to recognized drug screens conducted either at random or upon request by the program staff. I understand that if these tests indicate the presence of alcohol or drugs for which no acceptable reason can be offered, I may be discharged from the program. I also understand that the results of these drug screen may be shared with other agencies or individuals as required by law and allowed by the consent forms I have on file.

• I understand that I may be asked to go to a local laboratory at my own expense for the purpose of conducting drug screening and that a refusal to either submit to a test at the Set Free facility, or my refusal to get a drug screen conducted at a laboratory within a specified amount of time will be considered a failed test.

• I understand that Set Free Alaska uses Millennium Health Lab which will be billed directly to our clients. The private insurance and Medicaid information will be provided to Millennium Health for the purpose of billing. If you are Self-Pay you will receive a separate bill from Millennium Health. I understand if my Clinician/Counselor chooses to use a 13-panel instant read cup I will be charged $20.

_____
Print Child Name

_____ _____ _____
Signature of Parent/ Guardian | Print Parent and or Legal Gaurdian Name | Date

Understanding Set Free Alaska's Children's Program Waitlist Policy

Once your paperwork is completed and the clinical team has reviewed your file, you will be added to the waitlist. Priority standing on our waitlist is at the discretion of the children's clinical team.

We will contact you to notify you that you have been placed on our waitlist and/or to schedule an assessment. We send out a notification text message and/or email you to notify you that your child has been placed on the waitlist.

The below information to help you understand our waitlist protocol.

- Our reception team will contact the next individual on the waitlist to set up an assessment appointment. If a voicemail is available a message will be left. We will also reach out via text or email again.
- The number that appears on your caller ID will be 1.907.746.4799. We recommended saving this number in your phone contacts.
    - The individual has 24 hours to return our phone call for the next available spot.
    - If an individual does not call in 24 hours, their spot on the list will remain if they contact Set Free Alaska within seven days of the first message. If no contact the spot on the waitlist will be removed.
    - Three attempted calls with no contact will result in the individuals' file being closed out and being removed from the waitlist.

UNDERSTANDING SCHEDULING THE ASSESSMENT APPOINTMENT

If you have private insurance or do not have insurance, there is a $80 fee for an assessment. If you have Medicaid the cost of the assessment will be covered if treatment is recommended from the assessment. If treatment is not recommended there will be a $80 fee that will need to be paid.

If you need to reschedule or cancel the assessment appointment you need to contact Set Free Alaska within 24 hours prior to your appointment or, there will be a $25 rescheduling fee; or you could be removed from the waitlist.

If you are more than 15 minutes late or miss your scheduled appointment you will not be seen and will need to pay a $25 dollar rescheduling fee.

Please note if an assessment appointment is scheduled and missed without the appropriate communication, you will not be rescheduled and will be removed from the waitlist.

If you are removed from the waitlist for the above conditions, you may be added back to the waitlist after submitting paperwork and restarting the review process again.

Would you like a copy of Set Free Alaska's waitlist policies? Circle one: Yes or No

By signing this document, you understand the above protocols and policies.

_____
Child's Name

_____ _____ _____
Signature of Legal Guardian or Representative | Relationship to Child | Date

Client Financial Responsibility Agreement

Thank you for choosing Set Free Alaska, Inc. (hereafter referred to as "SFA") as your treatment provider. We are committed to providing you with quality services. SFA must obtain a valid copy of your identification, current Insurance information and proof of income when applicable.

Insured (Including Medicaid): All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered.

****Important Notice Regarding Medicaid***.

** Please be aware that, at this time Medicaid will only pay for one assessment every six months. The assessment must have a diagnosis or level of care for Medicaid to pay for it. If you don't have a diagnosis or level of care you will be billed for an assessment at the sliding scale fee. **

Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. It is your responsibility to notify this office immediately if your insurance coverage changes. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current.

When possible, we will bill your primary insurance company (including Medicaid) as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 60 days, we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, an invoice will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance

Insured/Non-Insured Payments: We accept cash, check, debit card, and credit cards for MasterCard and Visa.

Insured: Unless a payment plan has been agreed upon prior to the date of service, we will collect your deductible, co-pay, and payment for any uncovered services as well as the client's portion as determined by insurance at the time of service.

Non-Insured/Under-Insured: If you do not have medical insurance the following applies: Unless a prior financial agreement plan has been signed and payments are current, you will be responsible for a minimum payment at the time of service for the service to be received that day, as well as any previous outstanding balance. We offer a 20% discount for payment in full at time of service.

Sliding Scale: I understand that to be eligible for the sliding fee scale I must provide current proof of income. (Most resent paystub or tax return). I also understand that I must notify Set Free Alaska of any changes or increases that cause me to be no longer eligible for sliding scale.

No-Show Fee: There is a $25.00 fee for missed appointments not cancelled within 24 hours of the scheduled appointment time. These charges are your responsibility and cannot be billed to insurance or Medicaid. This fee maybe waived situationally.

Collection Fee: There is a $25.00 fee for collecting UA samples using an instant-read cup. Use of Instant Read cups are at the discretion of the counselor providing the service.

ASAP Clients: In the event that there is an outstanding balance after sessions are complete, SFA will report to ASAP that client has attended all recommended sessions; however, is not treatment complete due to an outstanding balance.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you. Please call (907) 746-4732 for account management.

Release of Information: I assign benefits of my medical insurance contract or Medicaid to SFA and authorize payment directly to SFA. I authorize SFA to release medical information to payers as required for payment of claims for medical services.

Delinquent Accounts: Any unpaid charges over 90 days old will be considered for an outside collection agency. The Collection agency will receive client identifying, contact and financial information. You are responsible for any collection, legal, or court fees incurred in the collections process.

Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility. We will discuss our professional fees at any time.

I have read and understand the payment policy and agree to abide by its guidelines:

Printed Client Name _____

Client/Guardian Signature: _____Date_____

REV.9.4.2020

Telehealth Informed Consent

Distance Counseling to Supplement Traditional Counseling

I acknowledge that I have received, read (or have had read to me), and understand the information provided to me about substance abuse treatment I am considering through distance counseling with the use of technology.

1. I consent to the use of Tele-counseling - Support and insightful discussion is done via telephone/personal cellular device at a designated time agreed upon by client and counselor.

2. I consent to Video conferencing on the web - Counseling can continue for clients through the internet videoconferencing programs that are secure and HIPAA compliant such as, but not limited to Zoom, Skype for Business, Microsoft Teams, or other similar programs. Counselor may also use webinar functionality of Microsoft online portal that will allow counselors to post notes, handouts or homework.

3. I consent that while attending individual/group sessions online or using a personal cellular device, family members, co-workers and friends will not be present. My participation will be conducted in a private non-public secure area free from distraction. It is highly recommended to utilize headphones during sessions.

4. I consent that I will only communicate through a computer/personal cellular device that I know is safe, i.e. wherein confidentiality can be ensured (Be sure to fully exit all online counseling sessions). I further consent, that if we are unable to connect or are disconnected during a session due to a technological breakdown, I will try to reconnect within 10 minutes. If reconnection is not possible, I will call to schedule a new session time.

5. I consent to contact 911 or go to the nearest emergency room if I am experiencing a crisis situation.

6. Electronic Confidentiality including Audio/Visual, Chat, Phone communication. I consent to transmit therapeutic chat exchanges using encrypted means such as Zoom, SKYPE or Microsoft Teams and understand that use of cell phones, text messages are not confidential. I agree to keep computer files referencing our communication using secure and encrypted measures.

7. I understand that non-compliance will result in being dropped from the session or prevented from further participation in telehealth.

_____	_____	_____
Printed Name of Client	Signature of Client	Date
_____	_____	_____
Printed Name of Parent, Guardian or Representative	Relationship to Client	Date

This is the section for Releases of Information (ROIs).

*Please read the ROIs carefully and make sure to write **clearly**.*

We have included a ROI for the parent and/or legal guardian of the child; this is so that Set Free Alaska can schedule appointments and contact the individual who has legal guardianship has the child.

Please DO NOT put "X's" on these forms as that is not allowable. Please initial by what information you would like to disclose.

We have included our disclosure of information; this is a notification of your rights and protections for your substance use records at Set Free Alaska, if applicable. Please sign, print, and date clearly if your child will be needing substance use treatment.

We have included examples on how to fill out all our ROIs. We do not need these forms back.

If any of these ROIs do not apply to you, please **do not** fill them out.

PARENT AND/OR LEGAL GAURDAIN OF MINOR

EXAMPLE

CONSENT FOR DISCLOSURE OF INFORMATION

I, Bruce Wayne (Parent/guardian/or representative) PARENT/LEGAL GUARDIAN OF Dick Grayson (Name of Child) DOB 04.28.2009 (Child DOB),
REQUEST/AUTHORIZE **SET FREE ALASKA** TO: BW (Initial) DISCLOSE INFORMATION TO AND/OR BW (Initial) OBTAIN

NAME OF PARENT AND/OR LEGAL GAURDIAN : Bruce Wayne

MAILING ADDRESS: 1234 Wayne Manor Lane Gotham, NY 12345

PHONE: 1(234)567-8910 FAX: 1(234)567-8911 EMAIL: bruce@wayneenterprises.org

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (INITIAL ALL THAT APPLY)

BW Initial ALL LISTED BELOW OR:

EXAMPLE

_____ ASSESSMENT/INTERPRETIVE SUMMARY
_____ TREATMENT PLAN
_____ TREATMENT REVIEWS/PROGRESS
_____ PSYCHOLOGICAL EVALUATION
_____ OTHER:_____
_____ UA/DRUG TEST RESULTS
_____ ATTENDENCE
_____ DISCHARGE SUMMARY
_____ FINANCIAL/PAYMENT INFORMATION

BW Initial ALL DATES of SERVICE OR: DATE or DATE RANGE of RECORD(S) to be released: _____

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

BW Initial ALL LISTED BELOW OR:

____ FURTHER TREATMENT/COORDINATION OF CARE
____ AT THE REQUEST OF CLIENT
____ LEGAL PURPOSES
____ FINANCIAL
____ PAYMENT & HEALTH CARE OPERATIONS
____ OTHER _____

EXAMPLE

INITIAL

BW I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form.

THIS CONSENT AUTOMATICALLY EXPIRES ONE YEAR FROM LAST DATE OF SERVICE WITH SFA (or upon completion of financial obligation, whichever is later) UNLESS OTHERWISE SPECIFIED. OTHER DATE/EVENT:_____

Bruce Wayne	adoptive parent	10.07.2020
SIGNATURE OF PARENT, GUARDIAN	RELATIONSHIP TO CLIENT	DATE

EXAMPLE

_____	_____	_____
SIGNATURE OF OTHER REPRESENTATIVE	PRINTED NAME OF WITNESS	DATE
_____	_____	_____
WITNESS SIGNATURE	PRINTED NAME OF WITNESS	DATE

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS ROI IS REVOKED _____ INITIAL

PO Box 876741
Wasilla, AK 99687
907-373-4732 Mat-Su(FAX 907-746-4749)
907-235-4732 Homer(FAX907-235-4733)

PARENT AND/OR LEGAL GUARDAIN OF MINOR

CONSENT FOR DISCLOSURE OF INFORMATION

I, _____ PARENT/LEGAL GUARDIAN OF _____ DOB_____,
Parent/guardian/or representative — Name of Child — Child DOB

REQUEST/AUTHORIZE **SET FREE ALASKA** TO: _____ DISCLOSE INFORMATION TO AND/OR _____ OBTAIN
Initial — Initial

NAME OF PARENT AND/OR LEGAL GAURDIAN : _____

MAILING ADDRESS:_____

PHONE:_____ FAX: _____ EMAIL: _____

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR:
Initial

_____ ASSESSMENT/INTERPRETIVE SUMMARY
_____ TREATMENT PLAN
_____ TREATMENT REVIEWS/PROGRESS
_____ PSYCHOLOGICAL EVALUATION
_____ OTHER:_____

_____ UA/DRUG TEST RESULTS
_____ ATTENDENCE
_____ DISCHARGE SUMMARY
_____ FINANCIAL/PAYMENT INFORMATION

_____ ALL DATES of SERVICE OR: DATE or DATE RANGE of RECORD(S) to be released: _____
Initial

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR:
Initial

____ FURTHER TREATMENT/COORDINATION OF CARE
____ AT THE REQUEST OF CLIENT
____ LEGAL PURPOSES

____ FINANCIAL
____ PAYMENT & HEALTH CARE OPERATIONS
____ OTHER _____

INITIAL
_____ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form.

THIS CONSENT AUTOMATICALLY EXPIRES ONE YEAR FROM LAST DATE OF SERVICE WITH SFA (or upon completion of financial obligation, whichever is later) UNLESS OTHERWISE SPECIFIED. OTHER DATE/EVENT:_____

_____	_____	_____
SIGNATURE OF PARENT, GUARDIAN	RELATIONSHIP TO CLIENT	DATE
_____	_____	_____
SIGNATURE OF OTHER REPRESENTATIVE	PRINTED NAME OF WITNESS	DATE
_____	_____	_____
WITNESS SIGNATURE	PRINTED NAME OF WITNESS	DATE

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS ROI IS REVOKED _____ INITIAL

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Wasilla, AK 99687
907-373-4732 Mat-Su(FAX 907-746-4749)
907-235-4732 Homer(FAX907-235-4733)

DISCLOSURE OF ALCOHOL AND DRUG TREATMENT INFORMATION

I UNDERSTAND THAT MY ALCOHOL AND/OR DRUG TREATMENT RECORDS ARE PROTECTED UNDER THE FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY AND DRUG ABUSE PATIENT RECORDS, 42 C.F.R. PART 2, AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), 45 C.F.R. PTS 160 AND 164, AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR BY THE REGULATIONS.

I UNDERSTAND THAT I MAY BE DENIED SERVICES IF I REFUSE TO CONSENT TO A DISCLOSURE FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, IF ALLOWED BY STATE LAW. I WILL NOT BE DENIED SERVICES IF I REFUSE TO CONSENT TO A DISCLOSURE FOR OTHER PURPOSES.

I HAVE HAD EXPLAINED TO ME AND FULLY UNDERSTAND THIS REQUEST/AUTHORIZATION TO RELEASE AND/OR OBTAIN RECORDS AND INFORMATION, INCLUDING THE NATURE OF THE RECORDS, THEIR CONTENTS, AND THE CONSEQUENCES AND IMPLICATIONS OF THEIR RELEASE. I UNDERSTAND THAT ONCE MY INFORMATION IS RELEASED, SFA CANNOT PREVENT THE REDISCLOSURE OF THAT INFORMATION, HOWEVER DOES PROVIDE A STATEMENT OF PROHIBITION AGAINST REDISCLOSURE OF PROTECTED HEALTH INFORMATION WITH DISCLOSURES MADE.

I UNDERSTAND THAT I MAY REVOKE A CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS CONSENT HAS ALREADY BEEN TAKEN. SEE RECEPTION FOR INSTRUCTIONS TO REVOKE A CONSENT. IF TREATMENT IS MANDATED AS PART OF PROBATION REQUIREMENTS, A CONSENT MAY NOT BE REVOKED UNTIL CONDITIONS OF PROBATION ARE MET OR PROBATION ENDS.

I HAVE A RIGHT TO RECEIVE A COPY OF THIS SIGNED AUTHORIZATION. I ALSO UNDERSTAND THAT UPON MY WRITTEN REQUEST, SFA MUST PROVIDE A RECORD OF DISCLOSURES MADE FOR LEGAL, ADMINISTRATIVE OR QUALITY ASSURANCE PURPOSES.

NOTICE

PROHIBITING REDISCLOSURE OF ALCOHOL AND DRUG TREATMENT INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly
permitted by the written consent of the individual whose information is being disclosed or as 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.

SIGNATURE OF CLIENT AND OR LEGAL GAURDIAN | PRINT NAME | DATE

PO Box 876741
Wasilla, AK 99687
907-373-4732 Mat-Su(FAX 907-746-4749)
907-235-4732 Homer(FAX907-235-4733)