Lake Health District

215 North G St.
Lakeview, OR 97630
541-947-6021
541-947-6020 Fax

INDIVIDUAL ADMISSION INFORMATION

Date: _____
Name: _____ Phone #:_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
SSN: _____ Date of Birth: _____ Grade Completed: _____
Parent/Guardian (if 17 or under): _____
Have you ever received services from our office under a different name? _____, if Yes please provide that name: _____
Emergency Contact: _____ Phone #: _____
Relationship to Individual: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Primary Care Provider: _____ Address: _____
City: _____ State: _____ Zip Code: _____
In case of a medical emergency, who should be contacted? (Name/Phone #): _____
In case of dental emergency, who should be contacted? (Name/phone #): _____
___ White (Non-Hispanic) ___ Black (Non-Hispanic) ____ Alaskan Native
___ Asian, Pacific Islander ___ Native American ____ Other Hispanic
___ Southeast Asian ___ Hispanic (Cuban)

Current Marital Status: ___ Married ___ Never Married ___ Widowed ____ Divorced
___ Living as Married ___ Separated

Current Military Status: ____ Active ____ Reserve ____ Retired

Living Arrangement: ____ Alone ____ Spouse ____ Parents, relatives, children
____ Institution ____ Friends or others ____ Homeless/shelter

Sources of Income: (check all that apply): ____ Wages, Salary ____ Social Security ____ SSI-Federal
____ Public Assistance/Welfare ____ Dividends/Interest ____ Pension, unemployment/vets
____ Alimony/Child Support ____ Other ____ Unknown

Employment status: __ Full time (35 hours or more) ___ Part time (17-34 hours) ___ Irregular (less than 17)
____ Not employed (seeking employment) ___ Not employed (and not seeking employment)

Any history of past or present legal problems? ___ Yes ___ No If yes explain _____
_____
Are you mandated to receive services here by any legal entity? ___ Yes ___ No If yes please provide a copy of the legal document.

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YOUR CONSUMER RIGHTS

Please read and sign this document as recognition of the fact that you have been supplied your consumer rights information, understand them, and have received a copy of your rights if you chose.

1. You have the right to have your privacy and dignity protected during treatment.
2. Community mental health and development disability services shall not be denied to any person on the basis of race, color, religion, sexual orientation, creed, sex, national origin or duration of residence.
3. No person shall, on the basis of handicap, be excluded from participation in, be denied benefits of, or other be subjected to discrimination under any program or activity.
4. No person shall be denied or be discriminated against on the basis of age or diagnostic disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability categories.
5. Any person eligible for mental health and developmental disability services provided by one agency shall also be eligible for other mental health and developmental disability services provided by any other agency, unless admission to the service is subject to the diagnostic or disability category or age restrictions based on predetermined criteria.
6. You have a right to have a treatment environment provided to you that affords reasonable protection from harm, and affords reasonable privacy.
7. You have a right to services provided to you in a setting under conditions that are least intrusive to your liberty, that are least intrusive to you, and that provide the greatest degree of independence.
8. You will receive no services without you or your guardian being informed of that service, and you or your guardian giving voluntary written consent, except as permitted by law.
9. You have a right to refuse service unless otherwise ordered by a court. If you do refuse services you have the right to not suffer any punitive consequences. If adverse consequences are expected to result from your refusal, you have the right to have those consequences explained to you or your guardian.
10. You have the right to be involved in, and have explained to you, the planning for treatment or training to be undertaken on your behalf, alternative treatment and training available if any, any risks that may be involved in your treatment or training.
11. You have a right to expect your records be maintained in a confidential manner.
12. You have a right to have access to, or a photocopy of, the policy and procedures explaining the compliance and grievance process.
13. You have a right to file a grievance or compliant, free from retaliation. If you chose, you have a right to receive assistance in filing that grievance or complaint.
14. You have a right to execute a declaration of mental health treatment.
15. No person shall be denied shall be denied mental health and developmental disability services based on your ability to pay, however you may be denied future services if you display an unwillingness to pay.
16. You have a right to have all information regarding your fees presented to you or your guardian in terms you understand.
17. You or your legal guardian have the right to know the amount and schedule of payment of any fees to be charged you.
18. You have a right to have services provided in written form or in alternative format or language appropriate to your needs.
19. You have a right to have services provided to you with awareness of and sensitivity to cultural differences.
20. You have a right to have services provided to you demonstrating awareness of, and sensitivity to, gender appropriateness and gender differences.

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CLIENT RESPONSIBILITY

Treatment programs at Lake District Wellness Center (LDWC) are designed to promote wellness by working with you. It is your responsibility as a client to be involved in developing a plan with the counselor for the services necessary to resolve your concerns. Further, it is your responsibility to share in carrying out the counseling plan, evaluating your progress, and modifying the plan as needed. You are a partner in the treatment process. You are responsible for making arrangement for payments of appropriate fees on time and to notify LDWC 24 hours in advance when you cannot make an appointment.

Lake District Wellness Center provides a Sliding Fee Scale that ensures all clients have the ability to pay for services. It is your responsibility to be willing to make all required payments for services.

CONSENT FOR TREATMENT

I understand my responsibilities and agree to receive services from Lake District Wellness Center. I understand that this document is available for my records and I only need to request a copy after signing.

NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I consent for treatment from LDWC, and I:

a. Have received a copy of Notice of Privacy Practices
b. Understand that the Notice of Privacy Practices provides and explanation of the ways in which my health information may be used or disclosed by Lake District Wellness Center and my rights with respect to my health information
c. Have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signed: _____ Date:_____
Client/Parent/Guardian

Signed: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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

I. Who We Are

This notice describes the privacy practices of Lake District Wellness Center and the individuals that work at Lake District Wellness Center ("we" or "us").

II. Our Privacy Obligations

We are required by law to maintain the privacy of medical and health information about you (**"Protected Health Information"**) and to provide you with this Notice of our legal duties and privacy practices with respect to Protected Health Information. When we use or disclose Protected Health Information, we are required to abide by the terms of this notice (or other notice in effect at the time of use or disclosure).

III. Uses and Disclosures With Your Consent

A. Use and Disclose With Your Consent. Except in emergency or other special circumstances, we will ask you to read and sign a written consent to our use and disclosure of Protected Health Information for purposes of treatment provided to you, obtaining payment for services provided to you, and for our Healthcare operation (e.g., internal administration, quality improvement, and customer services) (**"Your Consent"**) as detailed below:

- Treatment. We use and disclose Protected Health Information to provide treatment and other services to you, for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Payment. We may use and disclose Protected Health Information to obtain payment for services that we provide to you, for example, disclosures to claim and obtain payment from the Oregon Medicaid program or your health insurer, HMO, or other company that arranges or pays the cost of some or all of your healthcare (**"Your Payer"**) to verify that your payer will pay for healthcare.
- Healthcare Operations. We may use and disclosure Protected Health Information for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use Protected Health Information to evaluate the quality and competence of our psychiatrist, social works, nurse practitioners and other healthcare workers. We may disclose Protected Health Information to our patient advocate's patient representative in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

B. Uses and Disclosures of Highly Confidential Information.
When we are using or disclosing certain Protected Health Information about you that is highly confidential information, (**"Highly Confidential Information")**, we follow special procedures required by federal and Oregon law. Highly Confidential Information includes psychotherapy notes and Protected Health Information about: 1) mental health and development disabilities services;

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2) alcohol and drug abuse prevention, treatment, and referral; 3) HIV/AIDS testing; 4) venereal disease(s); 5) genetic testing; 6) child abuse and neglect; and 7) sexual assault. We use and disclose Highly Confidential Information with your knowledge and limited by a particular purpose. If we do not have any of your Highly Confidential Information, then this Subsection B does not apply to you.

IV. Uses and Disclosures only with your Authorization

A. As described in Section III above, our consent only permits us to use Protected Health Information for purposes of treatment, payment, and our healthcare operations. We may use or disclose Protected Health Information for any reason other than treatment, payment and healthcare operations only when: 1) you give us your authorization on our authorization form (**"Rights & Responsibilities"**) or 2) there is an exception described in Section IV below. Further, you may revoke Rights & Responsibilities, except to the extent that we have taken action in reliance upon it, by delivering a written revocation state to the Privacy Office identified below.

B. Uses and Disclosures of Highly Confidential Information with Your Authorization. As discussed in Section III, B above, Federal and Oregon Laws impose additional limitations on our use and disclosure of Highly Confidential Information even though you have already signed Your Consent. In order for us to use or disclose Highly Confidential Information for a purpose other than a purposed permitted under these laws, we must obtain Rights & Responsibilities.

C. Revocation of Rights & Responsibilities. You may revoke Rights & Responsibilities, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.

V. Uses and Disclosures Without Your Consent or Your Authorization

A. Use and Disclosure for Treatment, Payment and Healthcare Operations without Your Consent or Your Authorization. We may use or disclose Protected Health Information for purposes of treatment, obtaining payment, and our healthcare operations without your consent or Rights & Responsibilities under the following three circumstances: 1) when you requires emergency treatment, 2) when we are required by law to treat you and we attempt to obtain your consent, but are unable to obtain it, and 3) when we attempt to obtain your consent but are unable to obtain it due to substantial barriers to communicating with you, (e.g. you are unconscious or otherwise incapacitated) and you would have consented in the absence of the barriers.

B. Public Health Activities. We may disclose Protected Health Information for the following public health activities and purposes: 1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; 2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; 3) to report information about products under the jurisdiction of the US Food and Drug Administration; 4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and 5) to report information to your employer as required under laws addressing work related illnesses and injuries or workplace medical surveillance.

C. Victims of Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information without your consent or Rights & Responsibilities if we reasonably believe you are a victim of abuse, neglect or domestic violence to a government authority, including a social service or

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protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

D. Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency that oversees the healthcare system and/or ensures compliance with the rules of government health programs, such as Medicare or Medicaid.
E. Judicial and Administrative Proceedings. We may disclose Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. However, unless authorized by a court order, we may not use or disclose Protected Health Information identifying you as a recipient of substance abuse treatment or concerning such treatment if the purpose is to initiate or substantiate any criminal charges against you or to conduct any investigation of you.
F. Law Enforcement Officials. We may disclose Protected Health Information to the police or other law enforcement as required by law or in compliance with a court order.
G. Decedents. We may disclose Protected Health Information to a coroner or medical examiner as authorized by law.
H. Health or Safety. We may use or disclose Protected Health Information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
I. Specialized Government Functions. We may use and disclose Protected Health Information to units of government with special functions, such as the U.S. Military or the U.S. Department of State under certain circumstances.
J. Worker's Compensation. We may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs.

VI. Your Individual Rights

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to Protected Health Information, you may contact our privacy office. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Huma Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the director.
B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of Protected Health Information 1) for treatment, payment and healthcare operations; 2) to individuals (such as family members, other relatives, close personal friend, or any other person identified by you) involved in your care or with payment related to your care; 3) to notify or assist in the notification of such individuals regarding your location and general condition.
While we consider all requests for additional restrictions carefully6, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy office. We will send you a written response.
C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive Protected Health Information by alternative means of communication or at alternative locations.

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D. Right to Inspect and Copy your Health Information. You may request access to you medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Office and submit the completed form to the Privacy Office. If you request copies, we will charge you $0.10 (ten cents) for each page.

E. Right to Amend Your Records. You have the right to request we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is inaccurate and incomplete or other special circumstances apply.

F. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures or Protected Health Information made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge $0.10 (ten cents) per page of the accounting statement.

G. Right to Receive Paper Copy of the Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such Notice electronically.

VII. Effective Date and Duration of the Notice

A. Effective Date. This Notice is effective on July 1, 2007.

B. Right to Change the Terms of This Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms more effective for all. Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around Lake District Wellness Center. You may also obtain any new notice by contacting the Privacy Office.

VIII. Privacy Office

You may contact the Privacy Office at:

HIPAA Privacy Office
Lake District Wellness Center
215 North G St.
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CONFIDENTIALITY STATEMENT

The staff at Lake District Wellness Center will keep all information about your case confidential, including the fact that you are receiving services.

There are certain times that your information may be shared without your consent. These are as follows:

1. If you should require emergency medical attention;
2. If you report to us your intent to harm yourself or another person;
3. If you report to us that you are currently being abused or are abusing someone else such as a minor child or a senior citizen;
4. If your records are subpoenaed via a court order.

I have read and understand the above statement.

_____ _____

Signature Date

If you should have any questions regarding confidentiality or the sharing of confidential information, please discuss these with your counselor at the time of your appointment.

I have been offered voter registration information and assistance to register to vote.

_____ _____

Signature Date

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Lake District Wellness Center
Treatment Fee Agreement

Client Name (Please Print): _____

Please the following agreement in its entirety:
IF YOU HAVE OREGON HEALTH COVERAGE, you will not be charged personally for any covered service for as long you maintain OHP coverage.

IF YOU DO NOT HAVE OREGON HEALTH PLAN COVERAGE:

1. You are expected to pay for all direct services at the time you receive them unless you request a charge account that requires monthly payments. All non-direct services indicated on your treatment plan will be billed to an account in your name. All credit balances on your account will be refunded to you. Would you like to request a charge account? ___ Yes ___ No
2. If you do not cancel an appointment with Lake District Wellness Center at least 24 HOURS IN ADVANCE, you will be charged a "No Show" charge for your entire scheduled appointment. Emergency Exceptions may be considered appropriate verification, but will require written verification.
3. You will be charged Lake District Wellness Center's full rate for all services received unless you request and quality for an adjustment from our Sliding Fee Scale. Adjustments are based on your total household income and the number of people residing in your household. You will be required to provide proof to substantiate the income you report before an adjustment will be made. If your household income changes at any time during treatment, you are required to inform Lake District Wellness Center of those changes. If you choose to take advantage of our Sliding Fee Scale adjustment, the State of Oregon will pay the difference between what you are charged, and the full rate for each service. However, the State of Oregon will require notification of your participation in services and may audit your file for quality assurance purposes. You may choose to not allow Lake District Wellness Center to share this information with the State but this will disqualify you from receiving a sliding fee scale adjustment.

Do you wish to be considered for Sliding Fee Scale Adjustments? Yes ____ No ____
Total *monthly* income from all household members is: $_____
Total *annual* income from the household members is: $_____

TO BE FILLED OUT BY BILLING DEPARTMENT

SLIDING FEE SCALE	%		
HOURLY INDIVIDUAL RATE	$	HOURLY GROUP RATE	
		PSYCHIATRIST RATE	$
CHANGE OF SFS RATE:			
STAFF INITIALS		DATE OF ADJUSTMENT	
NEW HOURLY RATE	$	NEW GROUP RATE	$
		PSYCHIATRIST RATE	$
STAFF INITIALS		DATE OF ADJUSTMENT	
NEW HOURLY RATE	$	NEW GROUP RATE	$

Other services have fixed rates that the Sliding Fee Scale does not apply to. Please see attached Fee Schedule.

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By signing your name below, you are agreeing that you have read this document in its entirety and agree to all of the conditions specified herein.

Client Signature: _____ Date: _____

LDWC Employee Signature: _____ Date: _____

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Fee Schedule for Lake District Wellness Center that are NOT affected by the Sliding Fee Scale

Name of Service	Cost
1. Drug screening	$20.00
2. Quick Strip Test	$20.00
3. Breath Test	$20.00
4. ADES	$150.00
5. DVI Inventory	$150.00
6. DUSI Test	$40.00
7. BIP Class	$35.00
8. MIP Parent Meeting	$50.00
9. Costs to provide photocopies of Records	$.10 per page
10. CRT Meeting	$250.00

(Families are typically charged $50.00 with the remaining $200.00 being paid by EOHSC)

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CREDIT ACCOUNT AGREEMENT BETWEEN CLIENT AND LAKE DISTRICT WELLNESS CENTER

By signing my name below, I state that I understand the following conditions and that I agree to adhere to them in order to receive a charge account at Lake District Wellness Center.

1. Payments are required by the ____ day of each month.
2. My payment is determined by using an amount equal to 2% of my gross monthly income as identified on my Treatment Fee Agreement.
3. Based on 2%, I have the ability to pay $_____ or $10.00 per month, whichever is greater.
   Change monthly $_____ Date _____ Initials _____
4. I am aware that the late payment penalty is 1% of my outstanding balance or $5.00, whichever is greater.
5. If I have a delinquent account balance from previous services received, I will be required to pay that balance in full prior to receiving additional services.
6. Any credit balance on my account will be refunded to me.

Client signature: _____ Date: _____
Employee witness: _____ Date: _____

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Lake District Wellness Center
Grievance Procedure

Please read and sign the document as recognition of the fact that you have been supplied the grievance procedure, understand it, and have received a copy if you choose.

Any individual receiving services, the parent or guardian of the individual receiving services, or a provider acting on behalf of the individual with the individual's written consent may file a grievance with the Lake District

1. All clients will be informed of their right to file a grievance or complaints during the enrollment process.
    a. LDBH will accept both written and oral grievances.
    b. The right to file a grievance will be described in a way that the individual understands.
    c. Individual will be encouraged to resolve the grievance with LDBH but has the right to contact GOBHI or Governors Advocacy Office.
    d. The individual may request an administrative hearing if individual disagrees with an action.
    e. The individual may withdraw the grievance, appeal or administrative hearing request at any time.
2. Grievance policy will be posted in a conspicuous place stating contact phone numbers for the following:
    a. Lake District Hospital Phone: 541-947-2114
    b. Lake District Behavioral Health Phone: 541-947-6021
    c. Disability Rights Oregon Phone: 1-800-452-1694
    d. GOBHI Phone: 541-298-2101
    e. Oregon Health Authority Phone: 503-945-9716
3. LDBH will make available a supply of blank grievance forms in a conspicuous place.
4. LDBH will provide a convenient location for completed grievance forms to be deposited.
5. LDBH will acknowledge the receipt of each grievance to the individual either orally or in writing.
6. Individuals filing a grievance and witnesses or staff members of LDBH shall be informed that they will not be subject to retaliation by LDBH for making a report or being interviewed about a grievance or being a witness. Retaliation may include but is not limited to the following:
    a. Dismissal or harassment
    b. Reduction in services
    c. Reduction in wages or benefits (LDBH staff)
    d. Basing services (individual) or a performance review on the action
    e. Requesting disenrollment of a individual on the basis of implementation of an administrative hearing decision or a individual's request for an appeal or administrative hearing.
7. The grieving party is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.
8. Grievances will be forwarded expeditiously to the Director or his/her Designee, and an investigation of the grievance shall be conducted by LDBH staff members who have the authority and clinical expertise necessary to make clinical or administrative decisions throughout the grievance or appeal process. The Director will review the complaint and determine whether additional information is needed from the Member, representative or Provider to properly address the complaint. LDBH staff will begin to obtain documentation of the facts concerning the grievance upon receipt of the grievance.

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9. LDBH will resolve each grievance and will provide notice of the disposition as expeditiously as the individual's health condition requires.
    a. Standard Disposition of a grievance is within five working days from the date of LDBH's receipt of the grievance. LDBH will either:
        i. Make a decision on the grievance and notify the individual; or
        ii. Notify the individual in writing that a delay in LDBH's decision of up to 30 calendar days from the date the grievance was received by LDBH is necessary to resolve the grievance. LDBH will specify the reasons the additional time is necessary.
    b. Expedited Disposition will occur within 48 hours, as described later in this policy.

    If Members are dissatisfied with the disposition of their complaint, Member can present their complaint to the Governors Advocacy Office.
10. LDBH will provide a written decision on the individual's grievance that will address the following:
    a. The individual's specific concerns
    b. The reason for LDBH's decision
11. LDBH will ensure that the practitioner or staff member making the decision on the grievance has the appropriate clinical expertise in treating the grieving individual's condition or disease if the grievance involves clinical issues.
12. LDBH will safeguard the grieving individual's right to confidentiality of information about the grievance according to the restrictions contained in LDBH's HIPAA policies and procedures. LDBH shall have the right to use this information for the purpose of resolving the grievance and for the purpose of maintaining the grievance log required by OAR 410-141-0266.
13. All grievances filed with LDBH will be entered into a log and addressed in the context of quality improvement activity.
14. All grievances that the individual chooses to resolve through another process, and that LDBH is notified of, will be noted in the grievance log.
15. If the grieving individual chooses to resolve the grievance through another process, LDBH will make available all persons with relevant information and all pertinent files or clinical records to the hearing officer if deemed necessary prior to or during the administrative hearing.
16. LDBH will provide assurance in written, oral, and posted material of the individual's confidentiality in the grievance, appeal, and administrative hearing processes.

Expedited Grievances:

LDBH will expedite the review process of a grievance at the request of the individual or individual's representative when it is indicated that taking the standard time will jeopardize the individual's life, health, or ability to maintain maximum function. Expedited requests may be filed either orally or in writing based on the following:

1. If circumstances exist where the matter of a grievance is likely to cause harm to the individual before the grievance procedures outlined above are completed, then the member may request an expedited review.
2. The request for an expedited review will be evaluated by the Director or Clinical Supervisor.
    a. A response will be given orally and/or in writing to the individual within 48 hours of receipt of the grievance.
    b. The response will include information about the appeal process.

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3. If the individual disagrees with LDBH's resolution to the grievance, then he/she may request an expedited appeal with Greater Oregon Behavioral Health, Inc. (GOBHI).
    a. When LDBH receives a request for an appeal or expedited appeal, LDBH will notify GOBHI of such request.

4. Time frames may be extended up to 14 calendar days if:
    a. The individual requests the extension; or
    b. LDBH shows that there is a need for additional information and how the delay is in the individual's best interests.
    c. If LDBH extends the timeframe, LDBH will give the individual written notice of the reason for the delay.
5. If LDBH denies a request for expedited resolution, LDBH will do the following:
    a. Transfer the request to the time frame outlined for Standard Disposition.
    b. Make reasonable efforts to give the member prompt oral notice of the denial and follow-up with written notice within two days.
6. LDBH will ensure that punitive action is not taken against an individual requesting an expedited resolution as described in the Procedure section 6. (a-e).

Appeals: An individual that disagrees with a LDBH resolution may file an appeal with GOBHI or request an AMH administrative hearing. Individuals may not be required to go through a GOBHI appeal in order to request an administrative hearing. The procedures for an appeal is as follows:

1. An appeal must be filed with GOBHI no later than 45 calendar days from the date of the resolution.
2. The appeal can be filed with GOBHI or request an administrative hearing.
3. LDBH will assist GOBHI with the gathering of documentation in regards to the appeal.
4. If the individual asks for an administrative hearing by AMH, then the hearing request should be immediately transmitted to AMH's Hearing Unit. Upon notification by AMH after receipt of a hearing request, LDBH must review it through its appeal procedures as provided for in OAR 410-141-0264.
5. LDBH will give the individual reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an appeal or administrative hearing request. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.
6. LDBH will ensure the following:
    a. After being notified of a resolution, the individual has a right to file an appeal and request an administrative hearing;
    b. That each appeal is transmitted in a timely manner to staff having authority to act on it;
    c. That each appeal is investigated and resolved according to these rules; and
    d. That LDBH staff who make decisions on appeals have appropriate clinical training in treating the individual's condition or disease.
7. Appeals will be documented in the grievance log.
    a. These appeals will be reviewed in the context of quality improvement.
8. Appeals will be handled in a manner that is consistent with LDBH's HIPAA policies.
9. The process for appeals shall include the following:

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a. Provide that oral inquires seeking to appeal a resolution are treated as appeals and must be confirmed in writing, unless the individual requests expedited resolution.
b. Provide the individual a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
    i. LDBH will inform the individual of the limited time available in the case of an expedited resolution request.
c. Provide the individual with an opportunity to look over his/her file for information to be considered during the appeal process.

10. LDBH will resolve each appeal and provide the individual a notice of the appeal resolution as quickly as the individual's health condition requires with the following timeframes:
    a. Standard Resolution of appeals shall be resolved and the individual notified no later than 16 calendar days from the date the appeal is received.
    b. When LDBH grants a request for an expedited resolution to the appeal, LDBH will resolve the appeal and provide a client notification no later than three working days after receiving the appeal.
    c. LDBH may extend the timeframes of appeals up to 14 calendar days if:
        i. The individual request the extension; or
        ii. LDBH shows that there is a need for additional information and how the delay is in the individual's best interests.
        iii. If LDBH extends the timeframe, LDBH will notify the individual via written notice of the reason for delay.
11. For all appeals, LDBH will provide a written notice to the individual or the individual's representative. For notice on an expedited resolution, LDBH will make reasonable efforts to provide oral notice.
12. Written notice of the appeal will include the following:
    a. The results of the resolution process and the date it was completed.
    b. For appeals not satisfactory to the individual, the notice will include the following:
        i. Reasons for the resolution and a reference to the particular sections of the statues and rules involved; and
        ii. The right to request an administrative hearing from AMH and how to do so.
13. Unless the appeal was referred to LDBH as part of an administrative hearing process, the individual may request an AMH administrative hearing no later than 45 calendar days from the date of the resolution.
14. If an appeal was made directly by the individual and the notice of the appeal resolution was not favorable to the individual, LDBH will retain the complete record of the appeal for at least 45 days so that if an administrative hearing is requested, the record can be submitted to AMH Hearings Unit within two business days of AMH's request.
15. The individual has the right to drop the appeal at any point in the process.

Grievance Log:

LDBH will document all grievances received and administrative hearings requested by individuals via phone, fax, email, or by mail in a central log.

1. The grievance log will contain the following:
    a. Grievance
        i. The date of the grievance

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   ii. The nature of the grievance
   iii. The resolution of the grievance
   iv. The date of the resolution
b. Requested administrative hearing
   i. Final order of the administrative hearing

2. The Director, Clinical Supervisor, or Office Manager will be responsible for maintaining the documentation of all grievances.

3. LDBH will keep documentation of grievances and appeals for seven years.
4. Grievance log updates will be reviewed at the Quality Improvement meetings quarterly.

Client Signature: _____ Date: _____

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ALCOHOL AND OTHER DRUG MATRIX

SUBSTANCE (Circle)	Age First use	Age first regular use	FREQUENCY – QUANTITY	Method of Use	Last use & Amount
ALCOHOL Beer, wine, liquor					
SEDATIVE-HYPNOTICS Librium, Valium, Xanax, Ativan					
MUSCLE RELAXORS Robaxin, Soma, Flexeril					
STIMULANTS Speed, Meth, Cocaine, Ritalin, Crack					
NARCOTICS Diloudid, Vicodin, Heroin, Morphine, Demerol, Opium, Methadone, Darvon, Codeine, Percodan					
HALLUCINOGENS LSD, Mushrooms, PCP					
CANNABIS Marijuana, Hash, Bud					
INHALANTS Gas, Glue, Paint, Butyl					
OTHERS Over the Counter: Cough/cold medicine, diet aids, Nyquil, Benadryl, etc.					
ANTABUSE					
NICOTINE Smoke, Chew					

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Are you currently experiencing any of the following?

SYMPTOMS: (Please circle)

Anger, hostility, irritability
Difficulty concerning
Difficulty making decisions
Depression, sadness, crying
Feeling empty
Feeling fearful
Feeling guilty
Inferiority feelings
Impulsiveness, loss of control, outbursts
Judgment problems, risk taking
Martial conflict
Mood swings
Nervousness, tension

Panic or anxiety attacks
Procrastination, laziness
School problems
Sexual dysfunction
Sleep problems
Temper Problems
Changes in body weight
Work Problems, can't keep a job

Anxiety, nervousness
Confusion
Delusions
Eating problems
Fatigue, tiredness, low energy
Impulsive spending
Headaches
Conflicts with friends or family
Irresponsibility
Loneliness
Memory problems
Lack of motivation
Obsessions, compulsions (thoughts or actions that repeat themselves

Pessimism
Relationship problems
Self-neglect, poor self-care
Shyness, oversensitivity-criticism
Suspiciousness
Disorganized thoughts
Withdrawing, isolating self

What do you expect from treatment?

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INSURANCE INFORMATION STATEMENT

When I sign my name below, I state that I understand and agree to the following statements regarding any Private Insurance coverage I may utilize to offset the cost of services received from Lake District Wellness Center (LDWC).

1. It is my responsibility to pay LDWC for all services received.
2. It is my responsibility to get pre-authorization from my insurance company and LDWC may offer to assist with this process.
3. It is my responsibility to understand the extent and limitations of my insurance, including:
    a. Knowing how many sessions are authorized.
    b. Knowing when my authorized sessions are done.
    c. Getting additional authorizations when needed.
    d. Knowing what my co-pay is.
    e. Knowing what services my insurance company will or will not cover.
4. I will be requested to pay on my account while my insurance is being billed but, all overpayments to LDWC will be credited to me.
    a. Clients with EAP benefits are not required to make payments towards that balance.
5. I will never personally pay more than my Sliding Fee Rate for my services. If you are unclear ask for clarification.
6. All credit balances to my account will be refunded to me.

By signing my name below, I hereby agree to the fees and conditions set forth in this agreement.

Client Signature: _____ Date: _____

LDWC Employee Signature: _____ Date: _____