ORION
BEHAVIORAL HEALTH NETWORK

17025 Snowmobile Ln Eagle River, AK 99577
Telephone: (907)-696-7466 Fax: (907)726-0332
Email: Info@obhn.org

Patient Name: _____ Date of Birth: _____ Gender: M / F

Refer to patient as_____

Guardian Name: _____ Relationship:__ _____

Home Phone: _____ Cell Phone: _____

Guardian Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Primary Address:_____

City: _____ State: _____Zip:_____

EMAIL (REQUIRED):

_____

Need at least one email address for Guardian of patient

Preference for Reminder Messages: Text Message ____ Email____ Both____ None____

Emergency Contact (Other than Guardians) _____

Relationship: _____ Phone: _____

Parents are asked to check- in at least 15 minutes prior to an appointment. This allows for collection of insurance information and time for Nurse / Medical Assistant to check-in the child, a process which may include weight, height measurement, and blood pressure measurement.

Primary Insurance (Type): _____

Subscribers Name: _____ DOB: _____

Subscribers SSN #: _____

ID/Policy Number: _____ Group Number: _____

Secondary Insurance (Type): _____

Subscribers Name: _____DOB: _____

Subscribers SSN #: _____

ID/Policy Number: _____Group Number: _____

(Please Provide a copy of the Front and back of card before initial visit)

OBHN is no longer accepting Medicaid for talk therapy. If you have a private insurance with Medicaid secondary, you likely will have a co-pay for therapy services that will be your responsibility

School Information

Current School: _____
Grade: _____
Difficulties in school:

___ None ___ Frequent Suspension __ Detention ___Learning Problems __Poor Attendance

Is the patient on an IEP/504 Plan __YES __NO
Special Education ___ YES ___ NO

OTHER SCHOOL SERVICES_____

Guarantor Information

Relationship to Patient: _____
(Example: Biological Parent, Adoptive Parent, OCS and/or Guardian)

Name: _____

Date of Birth: _____

Address: _____

_____

Contact Number: _____

SSN(required):_____

Email Address: _____

Guarantor responsibility: Payment for all professional services rendered is the responsibility of the patient, parent, or guardian. When the patient has insurance that is reasonably expected to contribute toward payment for services, Orion Behavioral Health Network will assist in the preparation and submission of insurance claims. However, the Guarantor is responsible for all fees regardless of insurance coverage. Payment for all services, is due when services are rendered. Payment of coinsurance and deductible is done based on reasonable estimate. If additional funds are required after the insurance claim has been processed, any balance will be billed to the Guarantor. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the Guarantor. If insurance issues arise, it is the responsibility of the Guarantor to contact the insurance company, group plan administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier.

Signature: _____ Date: _____

Reason for Medical Evaluation

___ MOOD ___ Aggression ___Inattention ___Hyperactivity/Impulsivity ____Anxiety ___ Other

SERVICES PATIENT IS RECEIVING

___ SPEECH Office/Provider _____ Phone Number_____
___ OT/PT Office/Provider_____ Phone Number_____
___ Therapist Office/Provider_____Phone Number _____
___ ABA Office/ Provider _____ Phone Number _____
___ Other Office/Provider _____Phone Number _____

Medical History

Primary Care Provider (Office & Doctor): _____Phone: _____
Current Medications: _____ Dose _____
_____ Dose _____
_____ Dose _____
_____ Dose _____

Any Allergies? (if yes please explain): _____

Household Information

Mothers Full name: _____

Fathers Full Name: _____

Who has legal custody? _____

Who has medication consent? _____

Employer of Father_____

Employer Address:_____ Employer Phone Number:_____

Employer of Mother_____

Employer Address:_____ Employer Phone Number:_____

Who lives in the home with the patient?

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Trauma History

Has this patient experienced any of the following?

____ YES ____NO ____SUSPECTED Emotional Abuse?

____ YES ____NO ____SUSPECTED Sexual Abuse?

____ YES ____NO ____SUSPECTED Physical Abuse?

____ YES ____NO ____SUSPECTED Neglect?

____ YES ____NO ____ N/A If in OCS custody, lived in multiple foster homes?

_____ CONSENT FOR TREATMENT BY OBHN

The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, as to the results of any services provided to the patient, including but not limited to therapy, treatment, tests or procedures, while a patient of OBHN. It is understood by the undersigned that the Physicians, Nurse Practitioners, Physician Assistants and Therapists on OBHNS' medical staff exercise independent medical judgment in their treatment and evaluation of patients. The undersigned further understands that the physician(s), the physician(s) to whom the patient may be referred and other physicians who may consult or provide services to the patient may be employees of OBHN or may be independent practitioners who are not agents or employees of OBHN.

In the event of a divorce/multi-home families, OBHN will need a copy of the custody documentations from court. OBHN provides services and seeks involvement of both parents/interested parties within reason of a custody plan. If the custody is 50/50 shared then OBHN will require one parent to be the main contact/guarantor for any staff contacts and billing purposes.

_____ ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION FOR PAYMENT

In consideration of any and all treatment services rendered or to be rendered by OBHN, to the extent permitted by law, I hereby (I) irrevocably assign, transfer and set over to OBHN (II) all my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by OBHN during the pendency of the claim for care provided by OBHN. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) or insurance, but shall not be construed to be an obligation of OBHN to pursue any such right of

recovery. I hereby authorize the insurance company(ies) or third party payor(s) to pay directly to OBHN all benefits due for services rendered.

_____ GUARANTEE OF PAYMENT

The undersigned hereby agree(s) to guarantee the payment of the bill for services rendered by OBHN. The undersigned agree(s) whether signing as a guarantor or as a patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of OBHN in accordance with the regular rate and terms of OBHN. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due. If the custody is 50/50 shared then OBHN will require one parent to be the main contact/guarantor for any staff contacts and billing purposes.

_____ CONSENT FOR CONTACT WITH HEALTH STUDENTS

The undersigned acknowledges and gives permission for the patient to have contact with students of health professions during the patient's treatment. Students of health professions are supervised by a physician or nurse practitioner when they are at OBHN.

_____ COURT PROCEEDINGS-

OBHN provides clinical services and does NOT conduct Forensic or Custody evaluations. As such we will not take part in court actions or provide opinions on court issues. Such services are available elsewhere in the community and referrals may be given as appropriate.

_____ STAFF CONCERNS OR COMPLAINTS-

OBHN Follows the law and ethics code of standard when treating clients and their family/support system. If for any reason you have a concern or complaint please talk to the service provider or request for the Chief Operator Officer (COO) as the clinic does have a policy and standard for client/patient advocacy.

_____ REFILL REQUESTS-

Monitor your medication supply so that you do not run out between appointments. If you need a refill on a medication that you have previously received from our office:

- Please contact the pharmacy that filled/fills the medication
- Ask the pharmacy to submit an electronic refill request.
- Also, please ask the pharmacy to turn off any "auto refill" functions.

- **We do require 3 business days on all medication requests. Please take weekends and holidays into consideration when calling in for refills. For your safety, please inform us of any newly prescribed medications from other prescribers and of any medication allergies.**

_____ **ATTENDANCE/CANCELLATIONS/MISSED APPOINTMENTS AGREEMENT-**

Consistent attendance and active client participation is important for treatment to occur. Especially for a client and their family to meet any treatment goals it is the client's responsibility to attend all scheduled sessions. This allows the clinic to provide timely services and support for a variety of the clients who are waiting for appointments.

Appointments should be cancelled within 48 hours or more to avoid a $50.00 missed appointment or late fee,

I am aware that a message for cancellation can be left on the OBHN message line. The $50 fee will need to be paid at or prior to the next appointment. It should be noted that insurance companies do not cover these late fees and the client/family will be charged the fee. Also, if a fee is not paid in a timely manner it may delay/prevent the next appointment from being scheduled. Clients can utilize crisis services at 907-563-3200 or Providence Psychiatric Emergency Room during this waiting period.

*I understand that OBHN may discharge and close the client's case from the clinic after three appointments have been missed. These three "missed appointments" do include both medication management and therapy services combined within a six month period. There may also be a FULL FEE charge of the third/missed appointments.

*I understand that confirmation calls are a courtesy and that I am ultimately responsible for remembering my appointment.

_____ **EMAIL CORRESPONDENCE-**

The email address info@obhn.org is not an encrypted or secure email address. Any email correspondence to this address is not protected. The client/client family understands the risk of sending any health information to this address is not protected health information per the Health Insurance Portability and Accountability Act (HIPAA). OBHN is not liable for this risk.

-This also applies to the staff directory and email addresses. Once a client/guardian has made this form of alternate communication they have given consent for this level of correspondence.

_____ **TELE-HEALTH CONSENT-**

As part of you/your child's treatment at OBHN you/your child may be evaluated or treated by your/their treating Physician who will work with you from another location through a secure two way video and audio connection. You/your child would sit in front of a machine that looks much like a television and talk with the Physician whom you would see on the screen. This type of video consultation is called "Telehealth"

_____ **REQUEST OF OBHN RECORDS AND PROCEDURES-**

*OBHN follows the law and when psychiatric or mental health records are court ordered we must provide that court the records.

When another health care facility, mental health clinic, or academic setting request OBHN records an OBHN release of information must be in place. *Please note that OBHN does not charge the client/family for clinic to clinic records when they are used to continue necessary client care.

First step- Any request of records needs to be completed in writing and the requesting party must complete the OBHN "Release of Information" form which can be found at www.obhn.org under "The New Patient Forms" tab.

Records Approval process- A Licensed Health Care Professional, Psychiatrist, CEO of OBHN, or their designee must approve or deny requests for the client's electronic records to be released.

There are very few instances that a denial of records may occur but examples may include: Records that contain information subject to substance abuse or health issues. The request may breach confidentiality and could endanger the health or safety of that person. Or the information is generated in the course of ongoing research and the disclosure would jeopardize the research project.

Records Second step-
Cost of Records- OBHN charges a fee when personal use of records is requested and it is based on the number of pages.
-The first ten pages are at no-cost.
-After that, each additional page is $0.50 cents a page.
The fee must be paid at the time they are picked up.

Time frame to process the records- Once OBHN receives the records request form (Release of Information), it has been approved by a designated staff, and a fee has been quoted then the records are ready in 3-5 business days. If for any reason there is a denial of records/part of the record that decision will be made within that 3-5 day processing period.

_____PSYCHOTHERAPY SERVICES

OBHN offers treatment provided by licensed level therapy providers. The first session is an intake and starts a diagnostic/evaluation process; it can last from 2-3 sessions. Part of the intake process includes: deciding if the clinician is the best person to help support the client and a treatment plan with therapy goals will need to be written.

Length of Sessions

We usually schedule hourly appointments. Approximate lengths of sessions vary up to 55 minutes face-to-face. Although in some cases the sessions may be longer or scheduled more frequently. That can be determined between the client/family and therapy provider based on the needs of the case.

A note about privacy in psychotherapy sessions-a therapy session has a goal to build therapeutic rapport with the teen/clients therefore some additional privacy laws and procedures are followed. If parent/caretaker can agree to respect the therapy process then during the course of treatment general information/summaries about the progress of sessions will be given by the therapy provider. When additional information outside of a briefing/check in happens it may require a client's authorization before parents can be informed about various topics protected by law.

In the case of any psychiatric/psychological emergency (e.g. harm to self or others), clients can utilize a 24 hour crisis line at 907-563-3200, or go to The Providence Psychiatric Emergency Room in Anchorage and if deemed necessary call 911.

_____	_____	_____
Printed Name of Legal Guardian	Signature of Legal Guardian (For Minor or Incompetent Patients)	Date

_____	_____	_____
OBHN Staff who Reviewed Consents	Signature of OBHN Staff	Date

The parent/guardian either accepted_____ or declined_____ a copy of the consent to treat contract.

NOTICE OF PRIVACY PRACTICES

Orion Behavioral Health Network LLC
17025 Snowmobile Lane Suite 4
Eagle River, AK 99577-7044
Arom Evans MD 907-696-7466

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our

"business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise

use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths. 15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete.

 We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website (www.obhn.org).

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Copyright 2013 American Medical Association. All rights reserved.

Linda Yuu Connor, Regional Manager, 1-800-368-1019

OCRMail@hhs.gov The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

You will not be penalized in any way for filing a complaint.

I hereby acknowledge receipt of Orion Behavioral Health Network's Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

_____ _____

Patient's Name Date

_____ _____

Patient's Signature Date

_____

Guardian's Name

_____ _____

Guardian's Signature Date

Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____

29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Orion Behavior Health Intake Checklist	Re ce ntly	In the Pa st	**Evidenced By** (Please write a brief comment)
Please mark Recent in the past 30 days or less **Please mark in the past if it has happened…..**			
Sad mood most of the day			
Cannot fall asleep most of the time			
Sleeps more than usual			
Loss of energy			
Does not spend as much time with friends as usual			
Does not bathe or clean self regularly			
Eats more or less than usual			
Blames self			
Acts angry much of the time			
Acts unusually happy much of the time			

Orion Behavior Health Intake Checklist	Recently	In the Past	**Evidenced By** (Please write a brief comment)
At times needs little or no sleep			
Exhibits sexual behavior e.g. touching own or others privates			
Talks so fast it is hard to understand			
Tense, nervous, worries much of the time			
Panic attacks: heart pounding, can't breathe, sweating			
Saw or had something bad or scary happen			
Often remembers something bad or scary happening			
Has bad dreams over and over			
Becomes upset when reminded of something bad or scary			
Stays away from or will not talk about things that remind him/her of something bad or scary that happened			
Jumpy or scared easily			

Orion Behavior Health Intake Checklist	Recently	In the Past	**Evidenced By** (Please write a brief comment)
Seems to do things over and over without good reason e.g. washing hands, touching things, checking locked doors			
Has problems paying attention			
Is easily distracted			
Is often forgetful			
Often fidgets with hands or feet			
Lots of physical movement			
Talks a lot			
Behavioral problems in school			
Often acts without thinking			
Often loses temper			
Often argues			
Will not follow rules or directions			
Bullies, threatens or intimidates others			

Orion Behavior Health Intake Checklist	Recently	In the Past	**Evidenced By** (Please write a brief comment)
Starts physical fights			
Destroys property			
Steals			
Lies			
Runs away			
Cruelty to animals			
Fire setting			
School suspensions			
Change in school performance			
Other			
Does not make eye contact with others			
Has problems communicating			
Uses same movements over and over, i.e. wringing hands, rocking back and forth, clapping fingers			

Orion Behavior Health Intake Checklist	Recently	In the Past	**Evidenced By** (Please write a brief comment)
Does not notice when others are trying to speak or play with him/her			
Not interested in making friends or playing with others			
Is not easily soothed when upset			
Did not start talking until after 12 months old			
Does not play make believe			
Child has moved many times with different care givers			
Unchangeable false beliefs or ideas e.g. really believes that he/she has special powers or abilities			
Hears voices when no one is there			
Sees things when nothing is there			
Voices tell him/her to harm self			
Voices tell him/her to harm others			
Talks with words that do not make sense			

Orion Behavior Health Intake Checklist	Recently	In the Past	**Evidenced By** (Please write a brief comment)
Shows little emotion on face			
Refusal to maintain body weight within a normal range			
Very scared of gaining weight			
Thinks is fat when very skinny			
At times eats way too much food			
Exercises way too much			
Takes laxatives (ex-lax) to lose weight			
Forces self to vomit			

Patient Name _____ Date of Birth _____

ORION
BEHAVIORAL HEALTH NETWORK

This notice is to let you know that some insurance providers may not cover tele health services. Tricare and Medicaid do cover these services however some private insurers do not. Or they require special approval such as a single case agreement to cover telemedicine.

Please review your policy hand book or contact your current Insurance to clarify if they cover telehealth appointments. If your insurance does deny payment of tele health services, it is then the Guarantors responsibility to cover **ANY** cost that may be accrued during the visit.

If your plan does not currently cover telemedicine, we encourage you to contact your insurance provider (contact information is located on the back of your insurance card) and let them know that you would like for tele health services to be covered. Of Note Alaska recently passed a law requiring Private insurers to provide coverage for tele mental health. See below:

* Section 1. AS 21.42 is amended by adding a new section to read: 4 Sec. 21.42.422. Coverage for telehealth and mental health benefits. A health care insurer that offers, issues for delivery, or renews in the state a health care insurance plan in the group or individual market that provides mental health benefits shall provide coverage for mental health benefits provided through telehealth by a health care provider licensed in this state and may not require that prior in-person contact occur between a health care provider and a patient before payment is made for covered services.

* Sec. 2. The uncodified law of the State of Alaska is amended by adding a new section to read: APPLICABILITY. AS 21.42.422, added by sec. 1 of this Act, applies to a health care Enrolled HB 234 -2- insurance plan offered, issued for delivery, delivered, or renewed on or after the effective date of this Act.

_____ _____

PATIENT NAME: _____ EMAIL: _____

ORION
BEHAVIORAL HEALTH NETWORK

Virtual Health consent to treat

Please initial on the lines and sign at the bottom

_____In home tele-health is completely voluntary and patients can end treatment at any time without losing the ability to receive treatment at Orion Behavioral health.

_____Sessions will not be recorded by this clinic. It is expressly forbidden that the patient or family record or video the session.

_____HIPPA compliance will be maintained throughout the sessions. Security measures including encryption will be employed but security cannot be absolutely guaranteed. Limitations of confidentiality Suspicion of child abuse, neglect or threats to hurt self or others.

_____Back-up plan if connection fails, is that the patient calls the office (907)696-7466 and session will be finished via phone

_____Billing policy: patient will be billed the same as an in person evaluation. There will be a charge for facility fee and facilitation of telemedicine.

_____Web cam should be in a semi-public area of the house and there needs to be an appropriate adult present throughout the session. The clinician will be apprised of all people in the room. Sessions will only be held in the patient's house and not via portable devices unless explicitly authorized by clinician.

_____Liability waiver: OBHN or the provider will not be held liable for any technological difficulties that may arise on the computer or any physical damage to this equipment during the sessions. The patient and/or family are responsible for purchasing and maintain any equipment in their home. The patient and/or family are responsible for furnishing an adequate internet connection to allow the video conference.

_____ _____

Guardian/ Patient Signature Date

17025 Snowmobile Ln Eagle River, AK 99577
Phone:(907)696-7466 Fax: (907)726-0332

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____Today's Date:_____

Social Security Number:_____Date of Expiration:_____

Date of Birth:_____ Patient's Phone Number:_____

I,_____ , authorize Orion Behavioral Health Network (OBHN) to release and receive to/from: Name: the following information:

Phone Number:_____ Fax Number: (For Office Use)_____

I authorize OBHN to:

□ Send Info and Exchange Information (means that OBHN staff can communicate with the specific person, usually a therapist or doctor, and information can be shared between the two).

This information is for the purpose of: *(Please check only one box)*
(A separate Release Form must be filled out if more than one option is requested).

□ Continued Treatment □ Legal □ Personal Use □ Other (please specify):

I understand that the information to be released includes information regarding the following:

□ Drug/alcohol abuse, treatment, rehabilitation □ Psychiatric Treatment

Any information will not be released by the above named person or organization to any other persons or organizations unless I so authorize.

I understand that I may cancel this authorization, in writing, at any time. However, if we receive a written cancellation after information has been sent out, we will contact you. Without my written cancellation, this authorization will automatically expire (1) on satisfaction of the need for disclosure or (2) the authorizations will terminate as indicated in the “Date of Expiration” line at top of page. If no date is indicated in the “Date of Expiration” line, the request will terminate within 90 days from date of original request. I understand that I have a right to receive a copy of this request.

Signature of Patient:_____ Date:_____

Signature of Parent or Guardian:_____Date:_____

Relationship if other than Patient:_____ Date:_____

Witness:_____ Date:_____

If patient is a minor (17 and under), federal law requires the patient must sign to authorize the release of any drug and alcohol information.

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provisions of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

This Release of Information facilitates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder.” The Authorization for Release of Information must state that once the requested PHI is disclosed, the PHI’s recipient may re-disclose, therefore the Privacy Regulations may no longer permit it