
# Welcome to Compassionate Directions

**"Healthy Families, Strong Kids"**

We look forward to working with you. Your decision to come to Compassionate Directions (hereafter referred to as "CODI") is an important one and it is our desire that our relationship is beneficial to you and your family.

## CLIENT REGISTRATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Marital Status: M / S / D Maiden Name: _____

DOB: _____SSN: _____Sex: _____ Pregnant: Yes No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physical Address: _____City _____State _____ Zip _____

Mailing Address: _____City _____State _____ Zip _____

Email Address: _____

Preferred Language: _____English Fluency: _____Veteran Status: _____

Ethnicity:

- □ Not Spanish/Hispanic/Latino/Mexican
- □ Spanish/Hispanic/Latino/Mexican
- □ Puerto Rican
- □ Cuban
- □ Chicano/Other Hispanic
- □ Mexican
- □ Decline to answer

Race:

- □ Aleut
- □ Asian
- □ Athabascan
- □ Black/African American
- □ Caucasian
- □ Haida
- □ Inupiat
- □ Native Hawaiian
- □ Pacific Islander
- □ Tlingit
- □ Tsimshian
- □ Yupik
- □ Other Alaska Native
- □ Other American Indian
- □ Decline to answer

School Currently Attending: _____ Last Grade Completed: _____

Referred By: _____

Main: 360-249-9007 and 907-745-2634 Fax: 907-745-4897

Physical: 11921 E. Palmer-Wasilla Hwy, Palmer AK 99645 Mailing: PO Box 1907, Palmer AK 99645

- If Legal/Medical custody is shared between more than 1 Parent/Guardian/Responsible Party: BOTH PARTIES MUST INITIAL AND SIGN ALL REQUIRED CONSENTS AND AGREEMENTS WITHIN THIS DOCUMENT.
- **ALL CUSTODY DOCUMENTS MUST BE SUBMITTED WITH INTAKE PACKET**

## PARENT/GUARDIAN/RESPONSIBLE PARTY 1

First Name: _____ M.I.:_____ Last Name: _____

Relation to Client: _____Marital Status: □Married □Single □Divorced

Custody (choose all applicable):

□ 100% Legal/Medical □ Shared Legal/Medical: _____% □ Not Applicable

□ 100% Physical □ Shared Physical: _____% □Other: _____

Sex: _____ DOB: _____SSN: _____

Physical Address: _____ City _____ State ____ Zip _____

Mailing Address: _____ City _____ State ____ Zip _____

Contact Phone: _____ Secondary Contact Phone: _____

Email: _____

Employer's Name & Address: _____

Annual Household Income: _____ Can Contact for Appointments: □ Yes □ No

## PARENT/GUARDIAN/RESPONSIBLE PARTY 2

First Name: _____ M.I.:_____ Last Name: _____

Relation to Client: _____Marital Status: □Married □Single □Divorced

Custody (choose all applicable):

□ 100% Legal/Medical □ Shared Legal/Medical: _____% □ Not Applicable

□ 100% Physical □ Shared Physical: _____% □Other: _____

Sex: _____ DOB: _____SSN: _____

Physical Address: _____ City _____ State ____ Zip _____

Mailing Address: _____ City _____ State ____ Zip _____

Contact Phone: _____ Secondary Contact Phone: _____

Email: _____

Employer's Name & Address: _____

Annual Household Income: _____ Can Contact for Appointments: □ Yes □ No

**Emergency Contact:** _____**Phone:** _____

**Relationship to client:** _____

## INSURANCE

**CODI accepts Alaska Medicaid/Denali Kid Care insurance** however, **we are not in-network with private insurance** companies such as Premera Blue Cross Blue Shield, Aetna, and EBMS. As a courtesy, we will do our best to contact your private insurance company prior to your assessment to determine coverage but we cannot ensure coverage due to being an "out of network" provider. **It is YOUR responsibility to call your insurance provider and verify coverage PRIOR to services**. CODI will provide a list of service codes upon request.

**We will bill your insurance as a courtesy. You are responsible for any amount not covered by insurance**. Please be prepared to pay any co-pays or co-insurance at the time of service. Insurance does not cover the cost of court appearances, report preparation, or extended or frequent telephone calls and these services will be your responsibility.

**PARENT/GUARDIAN 1 INITIAL_____** **PARENT/GUARDIAN 2 INITIAL_____**

### PRIMARY INSURANCE

Insurance Name & Address: _____

Insurance Phone #:_____ Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Client: _____

SSN: _____ Date of Birth: _____ Sex: _____

Employer Name & Address: _____

### SECONDARY INSURANCE

Insurance Name & Address: _____

Insurance Phone #:_____ Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Client: _____

SSN: _____ Date of Birth: _____ Sex: _____

Employer Name & Address: _____

**CONSENT TO TREAT AND PAYMENT POLICY:** I consent to be treated and have my child treated by CODI. I authorize the release of any medical or other information to process to my insurance claims. I also acknowledge responsibility for payment of my account(s) regardless of my insurance coverage (i.e. all deductibles, co-pays, and unpaid balances.) **All payments are due at time of appointment.** I *Authorize Assignment* of benefits to this provider for services rendered. I agree to pay any collection costs, including interest or attorney fees in attempting to collect on any delinquent balances.

_____ _____

**Signature of Patient/Guardian/Responsible Party 1** **Date**

_____ _____

**Signature of Patient/Guardian/Responsible Party 2** **Date**

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## POLICIES AND PROCEDURES

**ASSESSMENT:** We will make every attempt to schedule your initial visit with a clinician who best meets your needs. However, **please be aware that the initial visit is an assessment**. **Assessment does not guarantee your child will be enrolled in CODI services**. You will be informed of a decision to enroll after the assessment has been reviewed by CODI staff.

**TREATMENT:** The decision to begin treatment is not made until after the assessment is completed. Your clinician will discuss with you your needs and expectations, and their recommendations. A treatment relationship does not exist until you and the clinician have both signed a treatment plan. For assurance of quality care, providers in this office may review cases and consult with supervisors and/or peers on an as-needed basis.

**PARENT/GUARDIAN 1 INITIAL_____** **PARENT/GUARDIAN 2 INITIAL_____**

*Caregivers/Guardians must attend ALL Treatment Plan meetings, as required by CODI policy, every 90 days.*

**PARENT/GUARDIAN 1 INITIAL_____** **PARENT/GUARDIAN 2 INITIAL_____**

*Caregivers/Guardians are expected to attend family therapy and/or parenting classes as recommended by the clinician.*

**PARENT/GUARDIAN 1 INITIAL_____** **PARENT/GUARDIAN 2 INITIAL_____**

**CONFIDENTIALITY:** We will not release information to anyone unless given written permission by the patient or their guardian if a minor. There are a few exceptions that require the release of confidential information: State law requires that the clinician act when the client may be dangerous to themselves or someone else. This means that others may be notified or involved to protect the client if he/she is suicidal, intends to harm another person, or is unable to provide self-care at a level necessary for basic survival. The law also requires the report of child abuse or elder abuse or neglect when there is a reasonable belief that it has occurred. In response to a court order, your clinician must testify or release records. This does not apply to a subpoena, which must be answered, but not with confidential information unless written approval from the client is obtained. We will release information to your insurance provider as needed/requested for claims processing. Please review our Privacy Practices for more information.

**PARENT/GUARDIAN 1 INITIAL_____** **PARENT/GUARDIAN 2 INITIAL_____**

**ATTENDANCE:** We request 24 hours notice to reschedule or cancel an appointment by calling us at 907-745-2634. You are responsible for remembering your appointments. REMINDER CALLS ARE DONE AS A COURTESY ONLY. This includes all appointments. For repeated "no call, no shows", services will be paused until the client, parent, and clinician can discuss engagement in services. If no contact is made, a discharge letter will be sent within 7 days of the last attempted contact.

**PARENT/GUARDIAN 1 INITIAL_____** **PARENT/GUARDIAN 2 INITIAL_____**

**Your initials above and signature below indicate you have read and understand these policies.**

_____ _____
Printed Client Name Client Date of Birth

_____ _____
Signature of Patient/Guardian/Responsible Party 1 Date

_____ _____
Signature of Patient/Guardian/Responsible Party 2 Date

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## CLIENT HISTORY

1. Is the client currently in residential treatment or acute hospitalization? □ Yes □ No
Admission Date: _____ Expected Discharge Date: _____Facility Name: _____

2. Has the client been in residential treatment or acute hospitalization in the past? □ Yes □ No
Admission Date: _____ Date of Discharge: _____ Facility Name: _____

3. Is there an existing referral for inpatient/residential care by a professional? □ Yes □ No

4. Does the client currently receive outpatient services? □ Yes □ No
If yes, where? _____

5. Actively seeking alternative outpatient services outside of the current provider? □ Yes □ No

6. Is there **past** OCS involvement? □ Yes □ No
If yes, what was the reason for the involvement? _____
_____

7. Is there **current** OCS involvement? □ Yes □ No
If yes, please briefly explain: _____
_____

**OCS Case Worker: _____ GAL: _____**

8. Is there Law enforcement or DJJ involvement? □ Yes □ No
If yes, please briefly explain: _____
_____

9. Is the client and or family currently in crisis? □ Yes □ No
If yes, please describe: _____
_____

10. Does the client have an Individual Education Plan, 504, or receive Behavior Support Services at the school they're attending?

□ Individual Education Plan □ Behavior Support Services
□ 504 □ No

**School Case Manager Contact: _____**

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# Functional Assessment

(Behaviors that are demonstrated on a consistent or repeated basis)

**Presenting Problem:** Please describe the current mental health and/or behavioral concerns that have led you to pursue treatment for the client (*You may use the end of this document to continue writing*).

_____

_____

_____

_____

_____

_____

**Academic:**

- ☐ Poor Academic Performance
- ☐ Suspensions/Expulsion
- ☐ Forced School Change or Alternative School
- ☐ Disrespect for Authority Figures
- ☐ Serious Disruptions
- ☐ Bullying Behaviors (engages in or experiences)
- ☐ Attendance Challenges
- ☐ Lack of Engagement with Peers

Other concerns at school (Please describe in detail): _____

_____

_____

**Home:**

- ☐ Destruction of Property
- ☐ Aggressive/Violent behaviors
- ☐ Threats or Threatening Behaviors
- ☐ Run Away Behaviors
- ☐ Lying/Stealing Behaviors
- ☐ Substance Abuse
- ☐ Sibling Rivalry
- ☐ Disrespect Towards Caregiver
- ☐ Isolation
- ☐ Family Conflict:_____

Other concerns at home (Please describe in detail): _____

_____

_____

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**Community:**

- ☐ Involvement with OCS/DJJ
- ☐ Destruction of Property
- ☐ Aggressive/Violent Behaviors
- ☐ Multiple Placements
- ☐ Criminal Activity/Thinking
- ☐ Lying/Stealing Behaviors
- ☐ Inability to Engage in Age-Appropriate Social Activities

Other concerns in community (Please describe in detail): _____

_____

_____

**Personal:**

- ☐ Inability to Maintain Hygiene
- ☐ Inability to Perform Daily Living Tasks
- ☐ Self-Harm (head-banging, cutting, suicidal attempts)
- ☐ Disordered Eating Behaviors
- ☐ Destruction of Personal Items
- ☐ Lack of Meaningful Relational Connections
- ☐ Trauma History

Other personal concerns (Please describe in detail): _____

_____

_____

## Please Select the Service(s) You Are Interested In:

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ In-School Behavioral Support
- ☐ After School or Community Based Behavioral Support
- ☐ Positive Parenting Program (Triple P)
- ☐ Circle of Security (Ages Infant-7)

CODI DOES NOT PROVIDE MEDICATION MANAGEMENT SERVICES

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## Diagnostic History: (Previous diagnoses made by a professional only.)

Diagnosing Provider: _____ Diagnosis Date(s): _____

Provider contact Information: _____

- ☐ Depression
- ☐ Attachment Disorder
- ☐ Posttraumatic Stress Disorder (PTSD)
- ☐ Disruptive Disorder/ODD/Conduct
- ☐ Learning Disabilities
- ☐ Autism Spectrum Disorder
- ☐ Mood Disorder/Bipolar
- ☐ Anxiety Disorder
- ☐ OCD
- ☐ ADD/ADHD
- ☐ Eating Disorder (Anorexia, Bulimia. Etc.)
- ☐ Personality Disorders
- ☐ Substance Use Disorders
- ☐ Schizophrenic Spectrum Disorder
- ☐ Fetal Alcohol Exposure/Spectrum Disorder (FASD)
- ☐ Traumatic Brain Injury (TBI)
- ☐ Borderline Intellectual Functioning
- ☐ Developmental Delays
- ☐ Other: _____

Has the client ever received a neuropsychological evaluation? □ **Yes** □ **No**

***IF YES, PLEASE PROVIDE A COPY OF THE NEUROPSYCHOLOGICAL EVALUATION WITH THE INTAKE PACKET.***

## Previous Mental Health Providers Seen:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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## Medical Information

Physician_____ Phone_____
Address_____ City_____ State____ Zip_____

Psychiatrist_____ Phone_____
Address_____ City_____ State____ Zip_____

Other Physicians_____ Phone_____

Current Medications_____

Allergies_____

**Please provide any additional information you feel would be important for us to know:**

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**Receipt of Policies**

I, _____, acknowledge that I have received a copy of and understand CODI's Grievance Policy, Client Rights Policy, Behavioral Interventions Policy, and Privacy Policy.

_____ _____

Signature Date

CODI's governing body and management provide a safe and healthy environment and provide necessary care to: keep staff and clients safe; enhance the client's quality of life; teach and increase good behaviors; and limit the use of crisis interventions.

## Behavior Management

CODI provides behavioral health care to individuals and their families who may be experiencing behavioral health concerns. CODI recognizes each person's right and responsibility to do their best to manage their own emotions and behaviors. CODI staff are trained to teach clients and their families a wide variety of skills to help support clients in managing their emotions and behaviors. CODI staff emphasizes building quality therapeutic relationships with clients and providing encouragement of positive behaviors.

1. CODI staff will be trained in teaching clients to manage their own emotions and behaviors utilizing a variety of skills, including behavioral (coping skills) and cognitive interventions, mindfulness skills, relaxation techniques, other non-restrictive means for individuals to manage their own behavior.
2. CODI staff will emphasize building therapeutic relationships with all clients.
3. CODI staff will use encouragement and praise for positive behaviors and building on client strengths to help with skill deficits, as well as motivational enhancement techniques.
4. CODI staff will be trained in a nationally recognized behavior management system consistent with CODI's policies emphasizing use of verbal de-escalation skills. Staff will be trained how to try to avoid use of restrictive techniques. The training will include:
    a. recognizing aggressive and out-of-control behavior and other contributing factors that may lead to a crisis;
    b. understanding how staff behavior can influence the behavior of service recipients; and
    c. the reasons we do not use restrictive interventions.
5. Staff Training on de-escalation will further emphasize:
    a. listening and communication techniques, such as negotiation and mediation;
    b. involving the person in regaining control and encouraging self-calming behaviors;
    c. separation of individuals involved in a disagreement;
    d. offering help to guide the person to a safe location;
    e. a break to allow the person to calm down; and

    f. other non-restrictive ways of de-escalating and reducing episodes of aggressive and out-of-control behavior.
6. CODI will not use restraint, seclusion or manual restraints.
7. If CODI believes the client or another individual is in imminent danger, they will make an attempt to work with clients to calm them but may also call the police for assistance. Calling the police will not be used as a form of discipline or as a result of only destruction of property.
8. If police intervention is needed, the treatment team will meet following this incident as soon as is feasible and debrief the situation reviewing what occurred including previous events and possible causes to create a plan with more effective strategies to prevent the need for this type of intervention in the future. The client will be included in this planning.

**Prohibited Interventions**

CODI seeks to use a strength-based, trauma-informed, and compassionate approaches for all service recipients.

CODI prohibits the use of restraint, seclusion or manual restraints.

Additionally, CODI prohibits corporal punishment; the use of aversive stimuli; interventions that involve withholding nutrition or hydration or that inflict physical or psychological pain; the use of demeaning, shaming, or degrading language or activities; forced physical exercise to eliminate behaviors; unwarranted use of invasive procedures or activities as a disciplinary action; punitive work assignments; punishment by peers; and group punishment or discipline for individual behavior.

CODI Policy and Procedure

Client Rights

Purpose: CODI takes the rights of clients seriously. We recognize and respect the personal dignity of each individual, as well as their confidentiality and their privacy. This philosophy will influence all of our practices and be reflected in our polices and procedures as well as our direct care to individuals.

1. CODI will post a statement of client rights in the lobby area for all clients, families and the public to view.
2. CODI informs all perspective new clients of their rights, as part of the intake packet, which is reviewed with clients during the initial assessment. This information will include: At initial contact clients receive and are helped to understand a written summary of their rights and responsibilities, including:
    a. a description of the client's rights, including the obligations the organization has to the client;
    b. basic expectations for use of the organization's services;
    c. hours that services are available;
    d. rules, expectations, and other factors that can result in discharge or termination of services; and
    e. a clear explanation of how to file grievances, or appeals.
3. Clients will also be provided information on the types of services provided at CODI to help them make informed choices regarding service providers.
4. Clients are informed of the need for them to be as open and honest as possible in order for staff to best get to know them and their needs and to participate as fully as possible in any and all decisions related to their treatment.
5. Clients have the right to receive treatment in an environment were they are treated in a non-discriminatory manner and where there is consistent enforcement of program rules, policies and expectations.
6. Staff will be trained in the clients rights during their initial orientation to the agency and annually.
7. CODI does not serve clients under the age of 18 without parental consent for any outpatient behavioral health services.
8. CODI will provide assessments for safety, problem solving, and referral information to youth under a contract with the Mat-Su School District. Only youth referred by Mat-Su School District staff or personal will be seen in this

manner. Intervention as listed above is limited to assisting the school conduct safety assessments, assist youth with problem solving of emergent needs and referral information. Records of these interventions are kept at the district and are considered part of the educational record and are not behavioral health records.

9. CODI will provide information on community resources to anyone who presents at the office or calls on the telephone regardless of age.
10. The organization accommodates the written and oral communication needs of clients by:
    a. communicating, in writing and orally, in the languages of the major population groups served;
    b. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed;
    c. CODI will not ask siblings or other family members who have an interest in the treatment to provide this translation but instead will rely on professional services with the exception of emergency situations or if pre-arranged translators become unavailable ;
    d. providing telephone amplification, sign language services, or other communication methods for deaf or hearing impaired persons;
    e. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and
    f. considering the person's literacy level.
11. When making decisions regarding a clients treatment their specific abilities as well as their need for adaptation to accommodate their visual, auditory, linguistic, motor abilities and cognitive abilities will be made.
12. Clients participate in all service decisions and have the right to:
    a. request a review of their care, treatment, and service plan;
    b. refuse any service, treatment, or medication, unless mandated by law or court order; and
    c. be informed about the consequences of such refusal, which can include discharge.
13. Clients receive a schedule of any applicable fees and estimated or actual expenses, and are informed prior to service delivery about:
    a. the amount that will be charged;
    b. when fees or co-payments are charged, changed, refunded, waived, or reduced;
    c. the manner and timing of payment; and
    d. the consequences of nonpayment.


# *NOTICE OF PRIVACY PRACTICES*

## THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

## PLEASE REVIEW IT CAREFULLY.

CODI is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact the CODI Privacy Officer.

### UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are enrolled in CODI services, a record of your services are made containing health and financial information. Typically, this record contains information about your condition, the services and/or treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate heath professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

### HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other CODI personnel who are involved in taking care of you. Different programs of CODI also may share health information about you in order to coordinate your care. We may also disclose health information about you to people outside of CODI who may be involved in your care.
- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at CODI may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all clients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols.

We may also combine health information about many clients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our administration for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of CODI including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of CODI property. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of clients.

## OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided CODI through contracts with business associates. Examples include educators/trainers, outside attorneys and an information technology services provider we use. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders**. 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.
- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with clients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave CODI.
- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
    - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
        - Prevention or control of disease, injury or disability
        - Reporting births and deaths;
        - Reporting child abuse or neglect;
        - Reporting reactions to medications or problems with products;

- Notifying people of recalls of products;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
- Notifying the appropriate government authority if we believe a client has been the victim of abuse or neglect. We will only make this disclosure if you agree or when required or authorized by law.

o *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

o *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

o *Reporting Abuse or Neglect:* Notifying the appropriate government agency if we believe a client has been the victim of abuse or neglect.

- **Law Enforcement**. We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at CODI; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

## OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of CODI, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

  *You must submit your request in writing to the CODI Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.*

- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for CODI.

  *You must submit your request in writing to the CODI Privacy Officer. In addition, you must provide a reason for your request.*

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for CODI; or

- Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.
  *You must submit your request in writing to the CODI Privacy Officer. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.*

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

  **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  *You must submit your request in writing to the CODI Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.*

- **Right to Request Alternate Communications**. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

  *You must submit your request in writing to the CODI Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.*

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

- *You may obtain a copy of this Notice at our website, www.CODIalaska.org*

  To obtain a paper copy of this Notice, contact the CODI Privacy Officer at: 907-745-2634.

## CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at CODI and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the CODI administrator.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with CODI or with the Office of Civil Rights Hotline: 800-368-1019 or via the website at: www.hhs.gov/ocr or at the following address: Medical Privacy, Complaint Division Office of Civil Rights, United States Department of Health and Social Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201.

To file a complaint with CODI, contact the CODI Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.


## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____ Medical Record No._____

I have been given a copy of CODI's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that CODI has the right to change this *Notice* at any time. I may obtain a current copy by contacting the CODI Privacy Official, or by visiting the CODI web site at www.CODIalaska.org.

**My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:***

_____ _____
Signature of Client Date

_____
Print Name

_____ _____
Signature of Birth/Adopted Mother Date

_____
Print Name

_____ _____
Signature of Birth/Adopted Father Date

_____
Print Name

_____ _____
Signature of Guardian/OCS Social Worker Date

_____
Print Name

**For CODI Use Only: Complete this section if you are unable to obtain a signature.**

1. If the client or parent/s and/or guardian is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

_____

_____

2. Describe the steps taken to obtain the client's or parent/s signature on the *Acknowledgement:*

_____

_____

_____

_____

Completed by:

_____ _____

Signature of CODI Representative Date

_____

Print Name

**File original in client's Business Office Record.**


# Grievance Policy

CODI maintains a formal mechanism through which applicants, clients, and other stakeholders can express and resolve grievances, including denial of service, which includes: the right to file a grievance without interference or retaliation; timely written notification of the resolution and an explanation of any further appeal, rights or recourse; and at least one level of review that does not involve the person about whom the complaint has been made or the person who reached the decision under review.

Policy:

1. CODI will strive to resolve any grievance as quickly as possible and ensure the rights and dignity of clients is protected.
2. Any stakeholder, parent, guardian, or client can file a grievance, and can do so without fear of intimidation or retaliation from CODI.
3. A stakeholder/ client/ parent/ guardian filing the grievance will be notified in writing of any findings.
4. The board of directors will be notified of any grievances filed.
5. Clients/ guardians/ and family will be notified of the grievance procedure in the intake packet. A sign will also be maintained in the lobby.

Procedure:

1. Grievance forms will be available upon request at the front desk, or can be emailed or faxed upon request.
2. CODI staff will assist any client in filling out the grievance form if requested.
3. An acknowledgement of receipt of the grievance by the Executive Director or designee will come verbally or in writing within 1 business day of receipt of the completed form.
4. The Executive Director or designee will review the form and will conduct an investigation.
5. A written response will be mailed within 5 business days of receipt of the grievance.
6. If upon receipt of the written response, if a client/ parent/ guardian feels the grievance has not been resolved, the decision can be appealed. To appeal, a client/ parent/ guardian will need to place a desire to appeal the decision in writing in some manner. If an appeal is desired it will need to be done within 10 days of receipt of the response. This is to ensure timely resolution of a grievance.
7. In the case of an appeal the President of Board of Directors will be notified by the Executive Director, of an unresolved grievance and will be asked to review the situation.
8. At this time a client/ parent/ guardian or CODI may also choose to ask the Department of Behavioral Health to become involved to help resolve the grievance.
9. Confidentiality shall be maintained throughout the grievance process.