ISLAND HOSPITAL

Psychiatry and Behavioral Health
2511 M Ave, Suite G
Anacortes, WA 98221
Phone: (360)299-4297 Fax: (360)299-4294

Welcome to Psychiatry and Behavioral Health at Island Hospital

Thank you for choosing Island Hospital Psychiatry & Behavioral Health. We ask that you complete the forms enclosed and return them to the clinic in the pre-paid envelope; you are also welcome to drop the completed forms off in person. **Once you return the enclosed forms to us, we will schedule your first appointment**.

There is a place to list your medications in the patient questionnaire. If you prefer, you can make a copy of your medication list or list your medications on a separate sheet of paper. Please include over the counter medications and vitamins.

Please bring your insurance card and personal identification. If you need to cancel or reschedule your appointment we ask that you give 24 hours notice.

We would like you to be aware that it may take 1-3 appointments to complete your assessment and plan of care. This process will help determine whether or not continued care can be established with this clinic.

Please do not hesitate to contact our office should you have any questions or concerns.

Failure to provide adequate notice for cancellation of appointments, a minimum of 24 hours, may jeopardize our ability to maintain you as a patient of this practice.

Thank You!

ISLAND HOSPITAL

PATIENT INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Race	Religion	E-mail Address
Daytime Phone	Marital Status	DOB	Social Security #	Gender
Mother's Name (If patient is a minor)	Father's Name (If patient is a minor)		

GUARANTOR	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Relationship to Patient	DOB	Social Security #	Gender
Employer			
Employer's Address	City	State	Zip
Employer's Telephone Ext.	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown		

PATIENT EMPLOYMENT	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown
Occupation	Employer
Address	City State Zip
Employer's Telephone Ext.	Employer's Telephone Ext.

PRIMARY INSURANCE	Primary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

SECONDARY INSURANCE	Secondary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

⇨ SEE BACK SIDE

NEXT OF KIN INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

PERSON TO NOTIFY	Last Name	First Name	Middle Initial
Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

MEDICAL CONSENT

I consent to all medical and surgical treatment, laboratory, diagnostic imaging and other medical procedures performed and prescribed by the health care provider during clinic visits.

_____ _____

Signature *Date/Time*

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

_____ _____

Signature *Date/Time*

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

_____ _____

Signature *Date/Time*

MEDICARE PATIENTS ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE TO PROVIDER & PATIENTS

Name of beneficiary: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished to me at Island Hospital Family Care Clinics. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature *Date/Time*

CHILD & ADOLESCENT PATIENT AND FAMILY INFORMATION FORM

IDENTIFYING INFORMATION

Date Completed: _____

Physicians Notes

Child's Name: _____ DOB: _____

Primary language (if other than English): _____ Gender:

Parent's primary language (if other than English): _____

Person answering questions: _____ Relationship: _____

Person who assisted in completing this form: _____

Who has current custody/guardianship of child? ☐ mother ☐ father ☐ both parents

☐ DSHS ☐ relative:_____ ☐ other: _____

If the Legal Guardian is someone other than the parents complete the following:

Name: _____ Relationship: _____

Address: _____ Phone: _____

REASONS FOR EVALUATION

Who referred you to Island Hospital? _____

What are your primary concerns about your child/adolescent? _____

When did your child/adolescent start having these issues? _____

What services would you like to receive (*please check all that apply)?*

☐ Evaluation Only ☐ Medication ☐ Therapy

Comments: _____

All patients are first provided with a comprehensive evaluation.
Are there any specific questions you would like answered by this evaluation?

_____
_____
_____
_____

CAREGIVER INFORMATION

My child currently lives with: ☐ home with biological or adoptive family or relative

☐ group care setting ☐ residential treatment facility ☐ foster care

☐ other; if so, where _____

Physicians Note

Parent/Caregiver Information:

Relationship to child: ☐ mother ☐ father ☐ biological ☐ adoptive ☐ foster ☐ step

☐ other: _____

Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Marital Status:_____ Years of Education/Degree: _____

Step Mother's Name (if applicable): _____

Step Father's Name (if applicable): _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Who currently lives in the household with the child other than the caregivers listed above?

Name	Gender	Age	Relationship
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

CHILD SOCIAL-BEHAVIORAL HISTORY

Physicians Note

Please list all current and past mental health services (inpatient and outpatient), counselors, therapists or agencies who have evaluated your child in the past: ☐ None

Type of Service	Service Provider/ Address	Dates	Results	Past/Current
				☐ Past ☐ Current
				☐ Past ☐ Current
				☐ Past ☐ Current
				☐ Past ☐ Current

Psychiatric medication history for mental health issues: ☐ None reported ☐ Unknown

Current	Past	Name of Medication(s)	Condition(s)	Prescribing MD	Dose/Schedule	Response/ Side Effects

Does your child have thoughts of harming him/herself or other people? ☐ Yes ☐ No

Does the patient have access to any firearms or weapons? ☐ Yes ☐ No

If yes, are the firearms/weapons locked up or otherwise secured? ☐ Yes ☐ No

History of violence/grief and loss

Has child been exposed to domestic violence? ☐ Yes ☐ No

Has child been a witness to violence or traumatic death? ☐ Yes ☐ No

Has child experienced death of parent/psychological parent? ☐ Yes ☐ No

Child abuse/neglect history

Has child had history of ☐ physical abuse ☐ sexual abuse ☐ neglect?

Has abuse/neglect been documented by CPS/Legal System? ☐ Yes ☐ No

Has the abuse history been previously addressed by a professional? ☐ Yes ☐ No

Does your child participate in any community activities (e.g. sports, church)? ☐ Yes ☐ No

Please describe forms of discipline which have been used in the home and their effectiveness: _____

Please list those qualities about your child that you consider to be strong positive points.

_____

Please list those qualities about your child that you consider to be strong negative points.

_____

Does your child have any attachment or bonding difficulties with a history of disrupted parenting before age 5? ☐ Yes ☐ No

Patient ID Sticker

Originator/Author: Thompson, Theodore Supervisor Psychiatry
Original: 12/02/2014; Approved: 01/18/2015; Reviewed: 02/03/2018
Printed copies are for reference only. Please refer to the electronic copy for the latest version

CHILD'S MEDICAL & PHYSICAL HISTORY

Physicians Note

Who is the child's primary doctor? _____ Phone # _____ Last seen _____

Is the child's general physical health good? ☐ Yes ☐ No

Serious and/or chronic illness now (or in past)? _____

Is your child having any sleep problems (e.g. too much/too little)? _____

Are immunizations up to date? ☐ Yes ☐ No

Has child had any history of **seizures** or **head injury**, **serious injuries/accidents**, or episodes with **loss of consciousness** ☐ Yes ☐ No

Has your child had any history of medical hospitalizations or surgeries? ☐ Yes ☐ No

Details: _____

Does your child have any pain issues or concerns? ☐ Yes ☐ No

Current ongoing use of ***non-psychiatric medications***, including homeopathic, naturopathic or other alternative medicine for physical health: ☐ None reported ☐ Unknown

Name of Medication(s)	Condition(s)	Prescribing MD	Dose/Schedule	Response/ Side Effects

SCHOOL/VOCATIONAL HISTORY

Is the patient currently enrolled in school? ☐ Yes ☐ No

Please indicate your child's attendance in the current and past quarter of school:

On average, my child is missing less than/more than (circle one) one day per week of school

School Name: _____ Phone # _____ Grade _____

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? ☐ Yes ☐ No

Child is designated: ☐ Serious behavioral disorder ☐ learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Self- contained classroom

☐ Special education classroom ☐ Inclusion in regular education (____ hours/day)

☐ Other: _____

Describe current daily functioning in school setting, including strengths and needs):

_____

Indicate if your child has had any trouble in school:

Peer relations ☐ Yes ☐ No Behavior ☐ Yes ☐ No Academic ☐ Yes ☐ No

Relationship to teacher ☐ Yes ☐ No

*Include copies of individual education plans (I.E.P, 504 etc.) school/psychological testing and report cards for this child

BIRTH AND EARLY INFANCY HISTORY

Physicians Note

This information should be provided as it relates to the biological parents of the child, if known. Was the pregnancy planned? ☐ Yes ☐ No ☐ Unknown

Any difficulty becoming pregnant? If yes, please explain: _____

Was the mother exposed to any of the following while pregnant: ☐ None ☐ Unknown

Type	List Specific Substances	Amount	Month of Pregnancy
Drugs			
Alcohol			
Tobacco			
Medications			
X-Rays			

Did the mother experience any significant illnesses during pregnancy?
☐ Yes ☐ No ☐ Unknown If yes, please provide details: _____

Length of pregnancy: _____ Age of mother: _____ Weight gain: _____

Describe labor and/or delivery with this child:
☐ Easy ☐ Difficult ☐ Natural (vaginal) ☐ C-section ☐Forceps
Please provide details on any labor/delivery problems: _____
_____

Were there any problems while the baby was still in the hospital?
(For example, prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): _____
Were there any difficulties during the baby's infancy?
(e.g. excessive crying, health problems, recurrent vomiting, "colic", poor suck, low weight gain)? _____

DEVELOPMENTAL HISTORY

Physicians Note

Do you have any concerns about your child's development? ☐ Yes ☐ No.

Do you perceive your child's development as being:
☐ average ☐ below average ☐ above average

Has your child had any formal developmental testing or received any early intervention services? ☐ Yes ☐ No

If yes, please provide details: _____

Please identify your child's developmental progress in the following areas:

Areas of Development	Compare your child's development to other children his/her age			Please comment on areas of strength and needs in your child's development
	Same as Others	Slower	Faster	
Gross Motor Skills (running, throwing ball, bicycling)	☐	☐	☐	
Fine Motor Skills (coloring, drawing, writing, scissor use)	☐	☐	☐	
Speech & Language Skills (pronunciation, vocabulary)	☐	☐	☐	
Self-Control Skills (impulse control, delaying gratification)	☐	☐	☐	
Self-Concept (child's opinion of self, abilities, worth)	☐	☐	☐	
Cognitive Skills (memory, comprehension, knowledge)	☐	☐	☐	

Is there anything else you would like us to know about your child that we did not ask?

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Information about family medical history can be very helpful in understanding current emotional and behavioral issues for children and adolescents seen in our clinic. Please indicate if anyone in your family has the following conditions. Check all that apply, past or present:

Condition/Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
Mental Retardation	☐	☐	☐	☐	☐	☐
Learning Disorder	☐	☐	☐	☐	☐	☐
Attention Deficit	☐	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐
Neurological Disorders	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐
Physical/Emotional Abuse	☐	☐	☐	☐	☐	☐
Sexual Abuse	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Suicide Attempts	☐	☐	☐	☐	☐	☐
Anxiety Disorders	☐	☐	☐	☐	☐	☐
Separation Anxiety	☐	☐	☐	☐	☐	☐
Specific Fears or Phobias	☐	☐	☐	☐	☐	☐
Obsessive-Compulsive Disorder	☐	☐	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Visual Disability/Problems	☐	☐	☐	☐	☐	☐
Deaf/Hard of Hearing	☐	☐	☐	☐	☐	☐
Tics/Tourette's Syndrome	☐	☐	☐	☐	☐	☐
Chronic Illnesses	☐	☐	☐	☐	☐	☐
Juvenile Delinquency	☐	☐	☐	☐	☐	☐
Arrests/Incarceration	☐	☐	☐	☐	☐	☐
Harassment by Peers	☐	☐	☐	☐	☐	☐
Homelessness	☐	☐	☐	☐	☐	☐
Teen Pregnancy	☐	☐	☐	☐	☐	☐
School Suspension/Expulsion	☐	☐	☐	☐	☐	☐
Special Education	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐
Miscarriages	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

ISLAND HOSPITAL

JOINT 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 IT CAREFULLY.

Island Hospital respects your privacy. It is required to maintain the privacy of your health information and to provide you with a notice ("Notice") of its legal duties and privacy practices. We understand that your personal health information is very sensitive. Island Hospital will not use or disclose your health information except as described in this Notice. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records generated by Island Hospital and its personnel, volunteers, students and trainees. This Notice also applies to other health care providers that come to Island Hospital to care for patients, such as physicians, physician assistants, therapists, and other health care providers who are not employed by Island Hospital, such as ambulance services and emergency medical technicians who may have brought you to the Hospital, unless those other providers give you their own Notice that describes how they will protect your medical information. The Hospital and these other health care providers work together to provide you with care and they will share your health information with each other as necessary to care for you, to obtain payment for that care, or for health care operations purposes, such as quality assessment and utilization review.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. Island Hospital is required to follow the privacy practices that are described in this Notice (which may be amended from time to time).

Permissible Uses and Disclosures Without Your Written Authorization
We may use and disclose your protected health information without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are legally permissible.

For treatment:
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:
- We request payment from your health insurance plan with your consent. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

For Appointments:
- We may use your information to contact you to provide appointment reminders.
- We may use your information to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required or Permitted by Law:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
  - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - to public health or legal authorities.
  - to protect public health and safety.
  - to prevent or control disease, injury or disability.
  - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Work Related Circumstances under the following conditions:**
  - the employer must have requested the health care service that was provided to the patient.
  - the healthcare service provided must relate to the medical surveillance of the workplace or be an evaluation to determine whether the individual has a work-related illness or injury.
  - the employer must have a duty under the Occupational Safety and Health Administration (OSHA), or requirements of a similar State law, to keep records on or act on such information.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request or in accordance with state and federal law.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

For fundraising:

- We may use your protected health information to contact you in an effort to raise money for our operations. We may also disclose your health information to a foundation that is related to us so that the foundation may contact you in an effort to raise money for our benefit. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

Permissible Uses and Disclosures that may be made without your authorization, but for which you have an opportunity to object:

You have the right to object to our use or disclosure of your protected health information for the following purposes. If you object, we will not use or disclose it for the purpose(s) you specify.

- **Notification of Family and Others.** We may release health information about you to a family member, other relative, close personal friend, or any other person you identify to us who is involved in your medical care, which is directly relevant to such person's involvement with your health care. We may also give information to someone who helps pay for your care. We may tell your family or friends your general condition and that you are in a hospital.

- **Disaster Relief Efforts.** We may disclose health information about you to assist in disaster relief efforts.

- **Directory.** Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
  - your name,
  - location,
  - general condition, and
  - religion (only to clergy).

Uses and Disclosures requiring your written authorization:
We may use and disclose your protected health information for the following purposes only after we obtain your written authorization for such uses:

- **Psychotherapy Notes**. We must obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes, (2) for our own training programs in which mental health students, trainees or practitioners learn under supervision to practice or improve their counseling skills, (3) to defend ourselves in a legal proceeding initiated by you, (4) required by law, (5) to a health oversight agency with respect to the oversight of the originator of the psychotherapy notes, (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

- **Marketing Communications; Sale of PHI.** We must obtain your written authorization prior to using or disclosing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Disclosures of Protected Health Information
Uses and disclosures not described in this Notice will be made with your written authorization. You may revoke any such authorization at any time by providing us with written notification of such revocation.

Your Health Information Rights
The health and billing records we create and store are the property of Island Hospital. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to agree to any restriction you may request, except if your request is to restrict disclosing protected health information to a health plan for the purpose of carrying out payment or health care operation, the disclosure is not otherwise required by law, and the health information pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You must make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to amend your health information. You must give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures made for purposes of treatment, payment or health care operations, disclosures you authorized, disclosures to you, incidental disclosures, disclosures to family or other persons involved in your care, disclosures to correctional institutions, and law enforcement in some circumstances, disclosures of limited data set information or disclosures for national security. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

- Receive a notification if we discover a breach of your protected health information, according to requirements under federal law.

For help with these rights during normal business hours, please contact:

Privacy Officer
Island Hospital
1211 24th Street
Anacortes, WA 98221
(360) 299-1300

Our Responsibilities

We are required to:
- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice and place the updated Notice on our website and post it in appropriate locations. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our Admitting or Medical Records departments to pick one up.

To Ask for Help or Report a Concern
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Privacy Officer
Island Hospital
1211 24th Street
Anacortes, WA 98221
(360) 299-1300

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at Island Hospital. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Web Site
We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.islandhospital.org.

ISLAND HOSPITAL

Name _____

BD / MR# _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices for Island Hospital.

_____ _____

Signature of patient (or personal representative) Date

_____ _____

Printed Name Relationship to patient

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This form will be retained in your medical record.

AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____ Medical Record #: _____

Former Name or Alias (if any): _____ Social Security #: _____

Daytime Telephone: _____ Birth Date: _____/_____/_____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I hereby authorize _____

_____

and/or Dr.(s) _____ to discuss my medical information with the following individuals:

Name:	**Relationship to Me:**	**Phone#:**

Expiration date of authorization or event: _____

SIGNATURE OF PATIENT AUTHORIZING DISCUSSION OF HIS/HER PERSONAL HEALTH CARE INFORMATION WITH THE ABOVE NAMED INDIVIDUALS:

_____	_____	_____
Date/Time	Signature of Patient or Legally Responsible Party	Relationship to Patient

ISLAND HOSPITAL

One Patient/One Facility per Request. For internal purposes only: M#_____ F#_____

***Patient Name:** _____ ***Date of Birth:** _____ Telephone #: _____

***Purpose of Disclosure**: □ Insurance □ Provider □ Attorney □ Personal □ Other: _____

INFORMATION TO BE RELEASED FROM:	*** INFORMATION TO BE RELEASED TO:**
Island Hospital Department/Clinic: _____ *(Organization/Person)* _____ *(Address)* _____ *(City, State, Zip)* _____ *(Phone/Fax)*	_____ *(Organization/Person)* _____ *(Address)* _____ *(City, State, Zip)* _____ *(Phone/Fax)* **OR:** Island Hospital Department/Clinic: _____

*** Type of information** *(check appropriate box):*

- □ **Pertinent Hospital Medical Records from date: _____ to date: _____**
- □ **Pertinent Clinic Medical Records from date: _____ to date: _____**
  (a fee may be charged for this service)
- □ **All Medical Records** *(a fee may be charged for this service)*
- □ **Images** *(specify type)* _____
- □ **Other** *(specify – discharge summary, operative reports, lab reports, billings, etc)* _____

***Patient Authorization*:**

I understand that my records may contain information regarding the diagnosis or treatment of the following conditions and give my consent to include them in this records request *(patient initials required):* ____ HIV/AIDS ____ sexually transmitted diseases ____ drug and/or alcohol abuse ____mental illness ____psychiatric condition

***This authorization is valid until _____ *(date) OR* when the following event occurs: _____**

(State when Island Hospital is no longer authorized to disclose your information based on this authorization. If no date or event is listed, the authorization will be effective for 30 days from the date signed by you)

Note: Authorization to disclose your information *to an employer or financial institution* can only be effective for a maximum of one year from the date signed by you. (Reference RCW 70.02)

Minors (defined by law as a person under the age of 18 years unless otherwise noted for specific conditions): A minor patient's signature is required in order to release the following information:

1. Conditions relating to birth control, abortion or prenatal services (at any age per Washington State Law)
2. Sexually transmitted diseases (if age 14 or older)
3. Alcohol and/or drug abuse and mental health conditions (if age 13 and older)

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to Island Hospital Privacy Officer, 1211 24th Street, Anacortes, WA. 98221.

I understand I have the following rights to:

- Inspect or receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I understand that once Island Hospital discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that the confidentiality of these records will be protected by Island Hospital and its clinics under the authority of Federal (HIPAA, 45 CFR parts 160 and 164) and/or State of Washington laws. I also understand that some of my records may be protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in these regulations.

By signing this page, I acknowledge that I have read and agree to the terms on this page.

***Signature** _____ ***Date**_____

(Patient or Person Authorized to give Authorization)

***If signed by person other than patient, provide reason, relationship to patient, or description of authority**: _____

***ID Confirmed**_____ ***Date Records Copied** _____ ***Copied By** _____ ***Department/Clinic** _____

ISLAND HOSPITAL

PSYCHIATRY & BEHAVIORAL HEALTH AT ISLAND HOSPITAL

NOTICE REGARDING PRESCRIPTION REFILLS

The nursing staff is authorized to refill a limited number and type of prescriptions. By law, certain medications require a handwritten prescription that must be signed by the provider and hand delivered to the pharmacy. Please make appointments far enough in advance so that you do not run out of your medications. At times, refills may not be given without an appointment scheduled and may only be given in the amount needed until that appointment. Often medication changes or dosage changes require an appointment and cannot be made over the phone. **Please allow at least 3 business days for all refill requests.**

CONTROLLED SUBSTANCES / BENZODIAZEPINES

Medications are an important part of effective treatment for many mental health conditions. The decision to start or to continue psychiatric medications is not one to be taken lightly. Our approach to psychopharmacology ("medication management") is designed to respect your individuality and to acknowledge the complexity of this intervention.

Medications are selected carefully. We are especially cautious about prescribing controlled substances, such as benzodiazepines - for example: diazepam (Valium), alprazolam (Xanax), clonazepam (Klonopin), and lorazepam (Ativan). We will not prescribe controlled substances at the initial interview. These powerful medications can be safely and ethically managed only in the context of an ongoing treatment relationship. Similarly, stimulatants (such as: Adderall, Ritalin, Concerta

PAIN MEDICATIONS

We do **NOT** prescribe pain medications.

ISLAND HOSPITAL

ISLAND HOSPITAL CLINICS
FINANCIAL POLICY

Thank you so much for choosing us as your health care provider. We are committed to providing you with the highest quality medical care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we believe it important for our patients to have a clear understanding of our expectations regarding their billing and payment arrangements. Please read and sign the following Financial Policy prior to your visit. Should you have any questions, please feel free to ask.

Patient Responsibilities: All patients must complete our "Patient Registration Form" before being seen by any of our healthcare providers. This must be updated at least once a year. *Full payment is due at time of service* unless you have a *current medical insurance card, which must be presented at each visit.* We accept cash, checks, and credit cards.
Contracted Insurance Companies: We will bill any insurance. If we are contracted with the patient's insurance company, we will accept as payment in full, all contracted insurance allowables (their payment, plus any co-insurance, deductibles and/or co-payments). If we are not contracted with the patient's insurance, payment must be made to the full amount of our charge. **If your policy has an office visit co-payment, you must pay the co-payment at the time of service.** Otherwise, an administrative fee may be billed. Please check with your specific insurance company to determine whether this clinic is a preferred provider.
Medicare: We accept Medicare assignment, which means the Medicare check will be sent to our office. If we are not contracted with your supplemental insurance company, we will courtesy- bill one time.
Payment by Check: If your check is returned for non-sufficient funds (NSF), we will charge a $20.00 fee to your account. If that happens, you will be asked to remit the amount of the original check, plus service charge, in cash or by credit card.

General Credit Policy: Finance Policy Review (Effective January 1, 2015)

Patients are required to pay balances in accordance with the following guidelines:

- Payments may be made using Cash, Checks, or Credit Cards. Statements may also be paid online.
  - Mastercard, Visa, American Express or Discover are accepted.
- Physician office and therapy visit co-pays are required on the date of service. Lack of co-pay payments for any visits may result in rescheduling of the service.
- Extended payment plans are available upon approval with a maximum extension of twelve (12) months and a minimum payment of $50.00 per month.
- Delinquent accounts will be referred to a collection agency at which time additional fees will be assessed.

If you are unable to meet these terms, please contact the Patient Accounting Office at (360) 299-1332, ((855)-440-4200 ext. 1332 to make arrangements
Fees: Our clinic is committed to providing you with the highest quality medical care. Our charges are based on a value scale developed by the American Medical Association and supported by most insurance companies. You are welcome to know what our normal charge is for any given service.
Minors: For a child of divorced parents, we expect all payments for co-payments, deductibles and non-covered services from whichever parent accompanies the child. We will not bill ex-spouses or parents but will be happy to provide you an itemized receipt upon payment for your reimbursement needs.

Repeated failure to keep scheduled appointments, repeated NSF checks, and/or failure to make timely payments on your account may result in the termination of medical care from our clinic for the entire family.

I HAVE READ AND FULLY UNDERSTAND THE
ISLAND HOSPITAL CLINICS FINANCIAL POLICY

Signature of Responsible Party | Print Patient Name / Date of Birth

Date Signed | Print Name of Responsible Party / Relationship

ISLAND HOSPITAL

PATIENT RIGHTS

References: Washington State Law (WAC 246 320-141), Medicare's Conditions of Participation for Hospitals and DNV GL (NIAHO) Accreditation Requirements.

You have the right to:

- Be treated and cared for with dignity and respect without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.
- Receive information in a way that you can understand.
- Be informed of your rights before care is provided or discontinued whenever possible.
- Have family or your representative and your physician be told of your admission.
- Personal privacy during personal hygiene activities, medical/nursing treatments and when requested as appropriate. This also includes protecting your personal information from release or disclosure without your prior consent
- Provision of care in a physically and emotionally safe setting and access to protective services when necessary for your personal safety and be free from all forms of abuse, neglect, or harassment
- Participate in the development of your pain management plan and receive effective pain management.
- Be involved and informed in all aspects of your care and including:
  - Accepting or refusing care and treatment offered to you
  - Resolving problems with care decisions
  - Having family input in care decisions if you desire
  - Give or withhold consent to participate in research projects or procedures
- Spiritual or pastoral care.
- Receive visitors of your choice unless it is clinically necessary to restrict visitors.
- Give informed consent before a high risk procedure is done.
- Be free from restraint or seclusion unless medically necessary to ensure your or others' physical safety. If restraint or seclusion is medically necessary, you have a right to safe implementation by trained staff.
- Be informed of unanticipated outcomes of care, treatment or services.

- Have advance directives for health care and for your care providers to respect and follow those directives. You have the right to request no resuscitation or life-sustaining treatment. You have the right to end of life care.

- Donate organs and other tissues according to regulations including input from medical staff and direction by your family or surrogate decision makers.

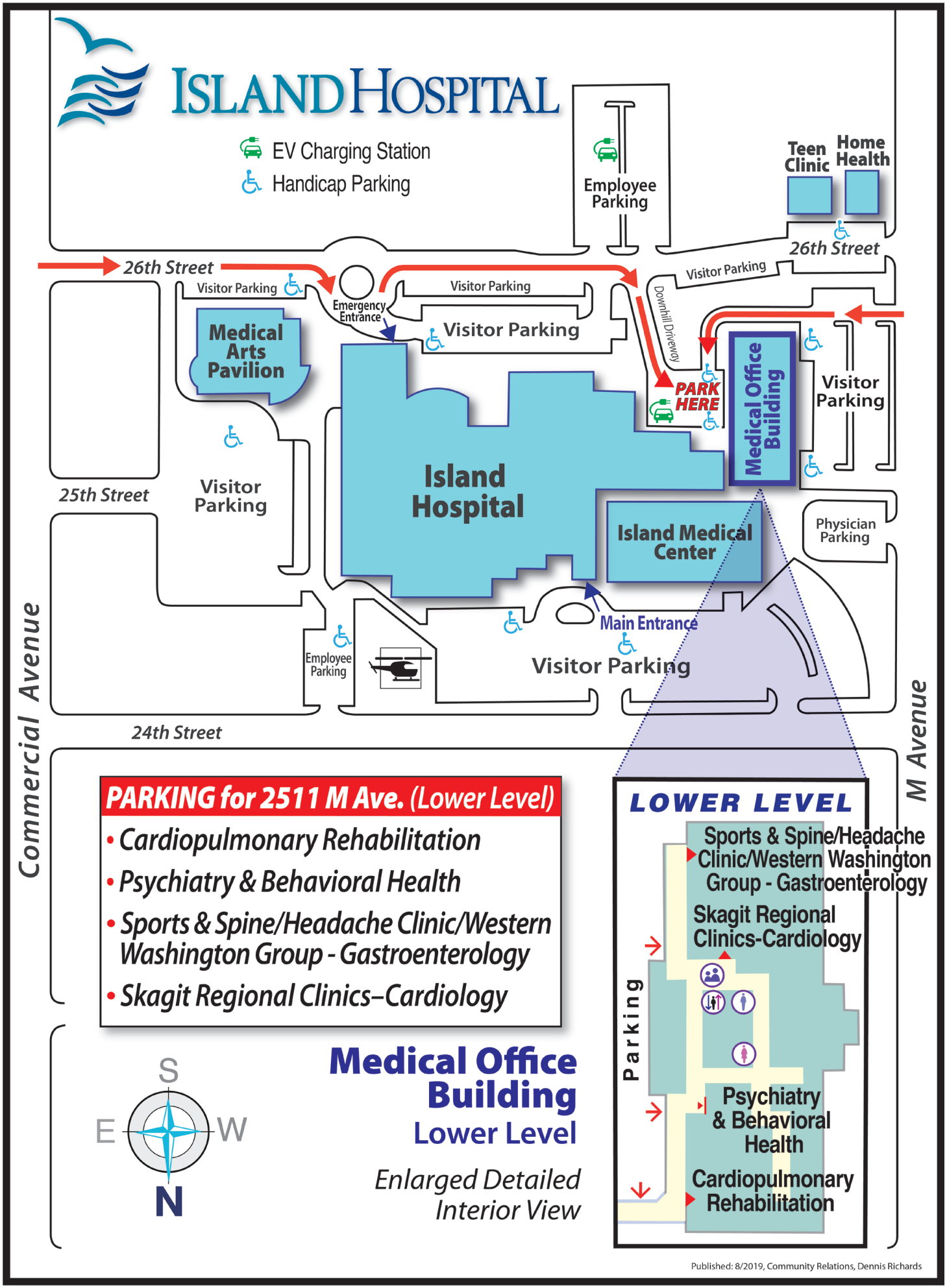
- Receive a Beneficiary Notice of non-coverage (if you are a Medicare patient) and appeal a discharge you believe is premature.

- Expect that all communications and records pertaining to your care will be treated as confidential; you have the right to review your own medical record and have access to information contained in your record in a reasonable time frame.

- Make a complaint about your care and treatment without fear of retribution or denial of care and to have timely complaint resolution.
  - If you have a concern regarding care or service, you may notify any staff member of your concern or ask to speak with management staff directly.
  - You may also contact the Director of Quality and Risk at (360) 299-1343.

  Additional Options:
    - Washington State Department of Health phone number: 1-360-236-4700.
    - DNV GL (Island Hospital's accrediting agency) at 1-866-523-6842.
    - If you are a Medicare beneficiary and have a complaint, you may contact Livanta at 1-866-815-5440.

- Examine and receive an explanation of your hospital bill.



Published: 8/2019, Community Relations, Dennis Richards