Client ID: _____

TREATMENT AGREEMENT, CONSENT & ACKNOWLEDGEMENT

What to expect:

First appointment: Your first visit will be with an admissions therapist who will provide a behavioral health assessment. At the end of this assessment, you and the therapist will discuss what services make sense. You will be assigned to a clinical provider who will be your clinical care coordinator. Your next appointment will be scheduled before you leave. You are welcome and encouraged to include friends and/or family at any point in your treatment process (with your written permission).

- **Clinical care coordinator:** This professional could be a therapist, a case manager, or other clinical provider, **based on the level of care you need** and agree to. You will participate in the development of your treatment plan with your clinical care coordinator. This treatment plan is your "map of care" that includes specific goals and milestones that you want to accomplish. This will also include clinical advice on when you can expect treatment to be complete. You will discuss what types of services will help you reach your goals. Your clinical care coordinator may also refer you for an appointment with a psychiatrist or a clinical nurse specialist at AllHealth Network to discuss medication.
- **Medical services:** As a health care agency, AllHealth Network expects frequent coordination with your primary care physician. In addition, if the psychiatrist or advanced practice nurse prescribes medications, there will be close monitoring and communication between you, the clinical care coordinator and our medical staff.
- **Completing treatment**: Our goal is for you to succeed in your treatment. When you and your care team determine that you have met your treatment goals and treatment is no longer indicated, your clinical care coordinator will discharge you from AllHealth Network care and provide referrals for aftercare if needed.
- **Scheduling:** AllHealth Network offers services at various locations and hours. We work to accommodate your scheduling needs to the best of our ability; however, your appointment may be during school or work hours. Please contact 303-730-8858 at least 2 business days in advance if you need to cancel or reschedule an appointment so that we can schedule another client.
- **Missed appointment:** Please call to cancel any appointments you are unable to keep. If you don't attend a scheduled appointment, we will call you to follow up. We want to know what the situation was that kept you from attending and work with you to solve problems, remove barriers, address your concerns, and attend to your recovery goals quickly and with exceptional care.
- **Exceptional care and staying in touch:** Please notify AllHealth Network of any changes in your telephone number, address, and/or your insurance coverage immediately, by calling 303-730-8858. If you are unhappy with services, please communicate this to any of your providers so we can find solutions to your concerns. You may also call the AllHealth Network Client Representative at 303-347-6405, who will work with you to resolve any concerns that you may have.
- **Client decision to stop treatment:** If you decide to stop treatment before your goals are met, please contact us so we can close your chart. If you stop treatment without contacting us, we will notify you by letter that we are discharging you and provide information about resources outside of AllHealth Network .With your written permission, we will send your records to a new provider. If you are being prescribed medications, we can provide a plan for safely stopping medications. You may contact us to request a limited prescription (generally 30 days) while you find another provider. Your primary care physician may be able to continue to provide you with medication services. Discharging from AllHealth Network means you will not be able to receive any further behavioral health treatment or medication. If you would like to start treatment again please call our Admissions Department at 303-730-8858.

Client ID: _____

Form #240 (5/14)

Advance Directives

What is an Advance Directive?

According to CMS-2104-F, Section 438.6(i)(1) and Colorado State law CRS 15-18.101-113, every competent adult has the right to make determinations on medical treatments, including the right to accept or refuse medical care and to exercise an Advance Directive. Advance directives are instructions written by you that inform your physician of your preferred treatment in the event of your incapacitation. It also allows you to designate a medical decision maker to make choices for you in the event that you are unable.

These laws require us to ask if you have an Advance Directive. While we are not able to assist you with completing advance directives, we will provide you with information and resources to support your decision making process.

Colorado Recognizes These Advance Directives:

Living will – (also known as Declaration as to Medical Treatment) This document tells your doctor how to proceed with life sustaining measures if you have a terminal illness or are in a persistent vegetative state and are unable to communicate your wishes. A living will also allow you to designate organ donation and the designation of your remains in the event of your passing.
CPR Directive –Allows for you to make your wishes known as to which methods, if any, you would like performed in the event your heart or breathing stops.
Medical Durable Power of Attorney – Allows for you to appoint a decision maker in the event you are terminally ill and unable to make your wishes known. The appointed decision maker would be designated as your "agent" and is expected to make decisions about your care when you are no longer able.
Proxy Decision Maker – Allows for the appointment of a designated decision maker if one has not already been appointed in the event you are unable to make decisions for yourself.

AllHealth Network and Advance Directives

Advance directives are not a requirement for you to receive care at AllHealth Network. It is your responsibility to provide your advance directive to AllHealth Network. If you provide us with your advance directive, AllHealth Network will provide care according to your written wishes, except as recognized in the Colorado Medical Treatment Decision Act (C.R.S. 15-18-102). You may amend or revoke an advance directive by informing the AllHealth Network privacy officer in writing to 155 Inverness Drive West, Englewood CO 80221.

If your provider refuses to honor your advance directives you can:

- Call the Behavioral Health Administration: 303-866-7400
- Call the Colorado Department of Public Health and Environment at: (303) 692-2980
- Or write to: Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver CO 80246-1530 or go to this website: http://www.colorado.gov/cs/Satellite/CDPHE-EM/CBON/1251589738636

This document is for your information only. It is not legal advice about advance directives. If you have questions, please consult an attorney who has experience with advance directives. You can visit www.coloradoadvancedirectives.com for additional information on creating advance directives.

DNS_AdvanceDirectivesFlyer_2/2016

Client ID: _____

FEE/BILLING POLICY

Thank you for choosing AllHealth Network as your behavioral health care provider. We are committed to providing you with outstanding care at the most affordable cost. In order to achieve these goals, we need your assistance and understanding of our financial policy.

ALL CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES AND/OR NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK AND MAJOR CREDIT CARDS.

- I understand that responsibility for payment of services for myself and my dependents is mine; due and payable at the time services are rendered, unless financial arrangements have been pre-made.
- As a courtesy, upon presentation of your current valid insurance card we will bill your insurance carrier. However, the entire balance is your responsibility whether the insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not party to that contract.
- You are responsible to know what services your insurance covers. You understand that should your insurance not cover specific services you may be responsible for the cost of those services.
- Financial assistance is available for qualified clients who are lawfully present in the United States and who can provide current proof of income, dependent(s) and address. A list of appropriate documents is available upon request.
- It is your responsibility to make sure that the insurance card provided is the most current and that all the personal information is correct including your name, date of birth, address and telephone number along with your primary care physician (if applicable). In the event that your insurance coverage changes to a plan in which we are a non-participating provider, you are responsible for payment in full at the time service is rendered.
- AllHealth Network is authorized to receive direct payment from your insurance carrier for any behavioral health and/or medical benefit services being rendered.
- AllHealth Network reserves the right to charge a $35.00 Insufficient Funds Fee for any returned items (checks and/or credit/debit card transactions).
- AllHealth Network reserves the right to charge a $30.00 No-Show Fee for all appointments cancelled without 24 hours advanced notice
- AllHealth Network reserves the right to add up to 25% of the total delinquent amount if your account is to be sent to an outside collection agency. You understand that you are responsible for all costs of collection including attorney fees, collection fees of 30%, and any additional court costs.
- Review of this financial policy and the completion of a financial intake are required annually.

Consent

I understand that by signing this fee agreement, I agree to treatment and commit to regular on-time attendance for all of my appointments. I understand that attending sessions will help me reach my treatment goals. I further understand and agree that two missed appointments or late cancellations in 90 days, failure to pay required co-payments or any combination thereof, could result in my care being moved to an alternative level of care, outreach attempts, or discharging me as a client if I don't respond. I understand that payment is due at the time of service. I understand that outstanding fees must be paid in order for me to be considered for re-admission. I am welcome to call admissions at 303-730-8858 to be considered for future services. I have been offered a copy of this agreement for my records.

_____	_____	_____	_____
Client Signature	Date	AllHealth Network Representative	Date

Client ID: _____

Client ID	Client's Last Name	First Name	M.I.
Client's Date of Birth	Client Social Security # (SSN)	Policy Effective Date	

PERSON FINANCIALLY RESPONSIBLE for CLIENT

Last Name	First Name	M.I.
Street Address		
City		
State	Zip	
Responsible Party's Date of Birth	Responsible Party's Place of Employment	
Responsible Party's Home Phone	Responsible Party's Work Phone and Extension	
Responsible Party's Relationship to Client (Circle One) Self Spouse Dependent Parent/Guardian Other		

PRIMARY INSURANCE POLICY HOLDER

Policy Holder's Last Name	First Name	M.I.
Policy Holders SSN	Policy Holder's Date of Birth	
Insurance Company Name	Insurance Company Phone	
Policy Holder's Employer		
Policy # / Group #	Insurance Type (Please Circle) I = Individual F = Family O = Other	

SECONDARY INSURANCE (ONLY COMPLETE IF YOU HAVE A SECOND INSURANCE PLAN)

Policy Holder's Last Name	First Name	M.I.
Policy Holders SSN	Policy Holder's Date of Birth	
Insurance Company Name	Insurance Company Phone	
Policy Holder's Employer		
Policy # / Group #	Insurance Type (Please Circle) I = Individual F = Family O = Other	

I have reviewed the Fee/Billing Policy. I understand that co-pays and deductibles are an estimate based on the information AllHealth Network has received from my insurance company and are subject to change. I have completed the requested information to the best of my knowledge. I have received a copy of this form. **I agree to assume responsibility and pay AllHealth Network the assigned Fee(s)/Insurance Fee(s).** I authorize AllHealth Network to release my information for all claims and payment purposes, as may be required by my insurance company or any third party payer, and release AllHealth Network from any liability related to such release of information. I assign all benefits and rights to payment for services provided by AllHealth Network, and authorize payment to be made directly to AllHealth Network by any third party payer that provides benefits or payment for such services.

Client Signature _____ Date _____ AllHealth Network Representative _____ Date _____

COMBINED STATEMENT OF MEDICAL DECISION-MAKING AUTHORITY

Client ID: _____

_____ _____
Minor child's or adult ward's name Date of birth

The Medical Decision Maker(s) listed and signed below state and attest that they may legally consent to medical, mental health and/or substance use treatment for the above listed minor child/adult ward if deemed necessary, advisable and appropriate by AllHealth Network and its employees, therapists, contractors, etc. I consent under the following authority:

- ☐ Never legally married: List the name of both parents
  - _____ _____
    Full Legal Name 1/relationship Full Legal Name 2/relationship
- ☐ Legally married: List the name of both parents
  - _____ _____
    Full Legal Name 1/relationship Full Legal Name 2/relationship
- ☐ Legally divorced or separated with custody orders from the court system:
  - I (name/relationship) _____ state and attest that I have sole medical decision making authority for the above named. **Name of other parent**: _____
    (Having medical decision making doesn't mean the other parent has no right to access information, unless court order overrules)
  - Medical Decision Making is shared:

    _____ _____
    Full Legal Name 1/relationship Full Legal Name 2/relationship
- ☐ Third party appointed Legal Guardian by court:

  _____ _____
  Full Legal Name 1/relationship Full Legal Name 2/relationship
- ☐ Self- Minor who is at least 12 years old and wishes to consent to services
  Note: Unless seeking substance use services, this will require clinical approval before beginning services.
- ☐ Department of Human Services
  - Specify Representative and County: _____
- ☐ **FOR DHS USE ONLY:** I also authorize (print name/relationship) _____to sign any and all papers necessary for the treatment of the minor child/adult ward listed above

I am aware that on (date) _____, an appointment for the minor child/adult ward listed above is scheduled for the purpose of a **mental health and/or substance use assessment** by AllHealth Network. I am also aware that following this assessment, it may be necessary, advisable and appropriate that the minor child/adult ward receives treatment from AllHealth Network. Without the generality of what "treatment" may involve, I understand it may involve individual or family therapy, group therapy, psycho-education, skills building, emergency services, counseling, care coordination, medication or a combination of one or more of these things.

PARENT OR LEGAL GUARDIAN WITH DECISION-MAKING AUTHORITY SIGN THE FOLLOWING:

_____ ____/____/_____
Signature Parent/Legal Guardian/DHS representative Date

_____ ____/____/_____
Signature Parent/Legal Guardian/DHS representative Date

_____ ____/____/_____
Signature of AllHealth Network Staff that reviewed information Date

#130 / Medical Decision Making authority / Legal

Client ID: _____

AllHEALTH NETWORK CONSENT

_____Yes _____No **Consent for treatment:** I voluntarily consent to evaluation and treatment for myself, or my minor child or ward, by qualified health care providers at AllHealth Network. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment. I understand that I have the right to consent to, or refuse to consent to, a proposed treatment and have the right to a second opinion regarding my diagnoses and my individualized course of treatment.

_____Yes _____No **Consent for follow-up contact:** I grant permission to the staff of AllHealth Network to contact me after my discharge from your services to obtain information for follow-up purposes only. All information obtained by AllHealth Network will be confidential, as defined by state and federal laws and regulations.

_____Yes _____No **Consent for telepsychiatry services:** Should I need psychiatric services at an AllHealth Network site where a prescriber is not at the same location, I grant permission to the staff at AllHealth Network to utilize telepsychiatry services. Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the client are not in the same physical location. The interactive electronic systems used in telepsychiatry incorporate network and software security to protect the confidentiality of client information and audio and visual data. I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry. I understand that the technology used by the prescriber is encrypted to prevent the unauthorized access to my private medical information. I understand that my withdrawal of consent will not affect any future care or treatment. I understand that the prescriber has the right to withhold or withdraw their consent for the use of telepsychiatry during the course of my care at any time as well.

_____Yes _____No **Do you have an advance directive?** Advance directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. If you wish, we can put a copy of your advance directives into your medical file. If you do not, you are welcome to talk with your primary care provider or call your insurance or Medicaid organization.

By initialing below I am acknowledging that I have been given/offered a copy of the following:

_____AllHealth Network Grievance information and copies of all signed documents
_____Treatment Agreement, Consent & Acknowledgement
_____Notice of Privacy Rights, including Confidentiality of Alcohol and Drug Use
_____Client Financial Information and Policy

_____	_____	_____	_____
Client/Guardian Signature	Client Date of Birth	Printed Name	Date Signed

_____ _____
Witness of AllHealth Network Representative Date

#150 / Consent to treatment/ Legal

Client ID: _____

DEMOGRAPHICS FORM - By answering these questions, you will help AllHealth Network better serve you. Your responses will allow us to provide more tailored programs and services to ensure that all clients receive the best care possible by meeting the diverse needs of our community. Your responses will be kept confidential and secure. Your uniqueness is valuable to our organization, please answer to the best **of your ability.**

Client name: _____ Client Date of Birth: ___/____/____

How do you describe your gender? (please select one)
- ☐ Female
- ☐ Male
- ☐ Non-Binary, Genderqueer
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Prefer not to answer

What is your sex assigned at birth?
- ☐ Female
- ☐ Male

What are your pronouns? (please select one)
- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ He/Him/They/Them
- ☐ They/Them/Theirs
- ☐ She/Her/They/Them
- ☐ Prefer not to answer

What is your sexual orientation? (please select one)
- ☐ Straight or Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual ☐ Queer
- ☐ Asexual ☐ Pansexual
- ☐ Prefer not to answer

Marital Status: (please select one)
- ☐ Never Married ☐ Married
- ☐ Married, separated
- ☐ Divorced ☐ Widowed

Place of Residence: (please select one)
- ☐Independent living (alone or w/ family) ☐ Residential/treatment group
- ☐ Inpatient ☐Homeless ☐ Nursing Home ☐ Assisted Living
- ☐ Halfway house ☐ ATU (Adults only) ☐ Sober Living
- ☐ Boarding home (adult) ☐ Group home (Adult only)
- ☐ Foster home (youth) ☐ Other Residential Facility
- ☐ Residential facility (MH adult) ☐ Correctional facility
- ☐ Supported housing

Living Arrangement (select all that apply):
- ☐ Alone
- ☐ With mother
- ☐ With father
- ☐ With sibling(s)
- ☐ With guardian
- ☐ With relatives
- ☐ With partner/significant other
- ☐ With spouse
- ☐ With children
- ☐ With unrelated person(s)
- ☐ Foster parent(s)

Current Primary Role: (please know these are state designated categories, select one)
- ☐ Employed (Full time 35+ hours/week) ☐ Employed (part time ≤ 35 hours/week
- ☐ Unemployed ☐ Military ☐ Retired ☐ Supported Employment
- ☐ Student (applies to age 0-18 only) ☐ Volunteer
- ☐ Homemaker ☐ Disabled ☐ Inmate

Emergency contact

Name: Relationship: Phone number:

#110 / Demographics Form / Administration

Client ID: _____

Gross annual household income: $_____
Number of individuals supported by this income: _____
Number of dependent children supported by income: _____

Does the client have a history of trauma?
☐ Yes ☐ No ☐ Unsure

Does the client received disability benefits?:
(select one)
☐ Yes, SSDI
☐ Yes, SSI
☐ Neither

Disabilities: (select all that apply)
☐ None
☐ Deaf/severe hearing loss
☐ Blind/severe vision loss
☐ Traumatic Brain Injury
☐ Learning disability
☐ Developmental disability

Educational Status: (please select the option last completed)
☐ Pre-Kindergarten ☐ Kindergarten ☐ Grade 1 ☐ Grade 2
☐ Grade 3 ☐ Grade 4 ☐ Grade 5 ☐ Grade 6 ☐ Grade 7
☐ Grade 8 ☐ Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 or GED
☐ Some college ☐ College Degree ☐ Master's Degree ☐ Doctoral Degree

Tobacco Status: (please select one)
☐ Current smoker/tobacco user- Every day
☐ Current smoker/tobacco user- Periodically
☐ Smoker/tobacco user- Current status unknown
☐ Former smoker/tobacco user
☐ Never a smoker/tobacco user
☐ Unknown if ever smoked/used tobacco

School information *if currently in school*:

Name of school: _____

School Address: _____

History of Mental Health Services: (select all that apply)
☐ Inpatient
Number of inpatient stays: _____
☐ Outpatient
☐ Other 24- hour care
☐ Partial Care
☐ None

Tell us what you think contributed to presenting problem: (select all that apply)
☐ Parental/family history/relationship
☐ Discrimination (any form) ☐ Genetics
☐ Isolation/disconnection ☐ Trauma
☐ Substance use ☐ Spirituality/Religion
☐ Physical, emotional abuse and/or bullying
☐ Employment ☐ Financial struggles
☐ Romantic relationship/partnership
☐ School ☐ Chronic physical illness
☐ Legal/Department of Human Services involvement
☐ Other: _____
_____

Previous or Concurrent Services: (select all that apply):
☐ Juvenile Justice
☐ Adult Corrections
☐ Developmental Disabilities
☐ Special Education
☐ Child Welfare
☐ Substance Use
☐ None

Presence of mental health problem: (please select one)
☐ Longer than 1 year
☐ One year or less

Number of arrests in the last 30 days:
_____

Is the client a veteran?
☐ Yes ☐ No

Family Members in the home:

Name:	Relationship:	DOB:

Client ID: _____

What is your race or ethnicity? (please select all that apply AND enter additional details in the space below)

☐ Decline to provide information

☐ White

☐ German ☐ Irish ☐ English ☐ Italian ☐ Polish ☐ French ☐ Other: _____

☐ Decline to provide additional detail

☐ Hispanic or Latino

☐ Mexican or Mexican American ☐ Puerto Rican ☐ Cuban ☐ Salvadoran ☐ Dominican ☐ Columbian

☐ Other: _____ ☐ Decline to provide additional detail

☐ Black or African American

☐ African American ☐ Jamaican ☐ Haitian ☐ Nigerian ☐ Ethiopian ☐ Somali

☐ Other: _____ ☐ Decline to provide additional detail

☐ Asian

☐ Chinese ☐ Filipino ☐ Asian Indian ☐ Vietnamese ☐ Korean ☐ Japanese

☐ Other: _____ ☐ Decline to provide additional detail

☐ American Indian or Alaskan Native

☐ Enter, for example, Navajo Nation, Blackfeet Tribe, Mayan Aztec, etc: _____

☐ Decline to provide additional detail

☐ Middle Eastern or North African

☐ Lebanese ☐ Iranian ☐ Egyptian ☐ Syrian ☐ Moroccan ☐ Israeli

☐ Other: _____ ☐ Decline to provide additional detail

☐ Native Hawaiian or Pacific Islander

☐ Native Hawaiian ☐ Samoan ☐ Chamorro ☐ Tongan ☐ Fijian ☐ Marshallese

☐ Other: _____ ☐ Decline to provide additional detail

Client ID: _____

Child and Adolescent Trauma Screen (CAT-S)- Youth report

Client Name: _____ Date completed: _____

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Please mark YES if it happened to you, and NO if it did not happen to you.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2. Serious accident or injury like a car/bike crash, dog bite, or sports injury.	☐ Yes	☐ No
3. Threatened, hit or hurt badly within the family.	☐ Yes	☐ No
4. Threatened, hit or hurt badly in school or the community.	☐ Yes	☐ No
5. Attacked, stabbed, shot at or robbed by threat.	☐ Yes	☐ No
6. Seeing someone in the family threatened, hit or hurt badly.	☐ Yes	☐ No
7. Seeing someone in school or the community threatened, hit or hurt badly.	☐ Yes	☐ No
8. Someone doing sexual things to you or making you do sexual things to them when you couldn't say no. Or when you were forced or pressured.	☐ Yes	☐ No
9. On line or in social media, someone asking or pressuring you to do something sexual. Like take or send pictures.	☐ Yes	☐ No
10. Someone bullying you in person. Saying very mean things that scare you.	☐ Yes	☐ No
11. Someone bullying you online. Saying very mean things that scare you.	☐ Yes	☐ No
12. Someone close to you dying suddenly or violently.	☐ Yes	☐ No
13. Stressful or scary medical procedure.	☐ Yes	☐ No
14. Being around war.	☐ Yes	☐ No
15. Other stressful or scary event?	☐ Yes	☐ No

Describe: _____

Developed by Prof. Lutz Goldbeck (Ph.D.) & Prof. Lucy Berliner (Ph.D.) The Child and Adolescent Trauma Screen (CATS) questionnaire is a brief, freely accessible screening instrument based on the DSM-5 criteria for Posttraumatic Stress Disorder (PTSD). There are no copyright or licensing fees associated with the assessment.

Client ID: _____

Social Determinants of Health Questionnaire

We would like to have a better understanding of environmental needs that may be negatively impacting your mental health. Please respond to the questions below in regards to the client we will be seeing and your clinician can discuss appropriate resources, if needed.

1. In the last 12 months did you ever eat less than you felt you should because there was not enough money for food? ☐ Yes ☐ No
2. In the last 12 months have you needed to buy clothing but were unable to? ☐ Yes ☐ No
3. Are you worried that in the next 2 months you may not have stable housing?

   ☐ Yes ☐ No
4. Do you have any physical health concerns for which you are not receiving adequate care?

   ☐ Yes ☐ No

DO NOT SCAN

Client ID: _____

Colorado Social Health Information Exchange (CoSHIE) Release Of Information

1. **My information**

   Client Name:_____ Todays Date: _____

   Client Date of Birth:_____ Client Last 4 digits of SSN: _____ Phone number: _____

   Client Preferred Gender: _____ Email Address: _____

   Mailing Address: _____

2. **Agreement**

   By signing this form, I agree to share the information listed below through the CoSHIE system. I understand that CoSHIE will share my information with trusted organizations, including care coordinators, to help me get social support resources like help with food, housing, healthcare, or transportation

3. **Information Shared**
   - First and Last Name
   - Contact information (such as phone number & mailing address)
   - Social Support Information (such as information that can help with access to food, housing, transportation, and similar needs collected by the Social Determinants of Health Questionnaire on previous page)

4. **Acknowledgements**

   Expiration

   I understand that my information will be shared with CoSHIE until I no longer agree that it can be shared.

   Revoking Consent

   I understand that I may stop sharing my information through CoSHIE at any time, but I must inform CoSHIE at http://CoSHIE.Colorado.gov.

   If I stop sharing my information through CoSHIE, I understand that it will stop sharing my existing and new information with any organizations to help me get social support resources.

   Copies

   I understand that copies of this form may be used in place of the original and that information covered by this release may be communicated electronically or by fax.

   I acknowledge that I have been offered a copy of this form and the CoSHIE FAQ sheet (next page).

   Initials: _____

   By initialing below, I consent to receive email, phone or text messages regarding my participation in the CoSHIE program in accordance with its Privacy Notice. I understand that I am not required to opt in as a condition of receiving any property, goods, or services. I understand that the text message & data rates may apply, and messaging frequency may vary.

   Initials: _____

5. **Signatures- If not consenting to sharing information please leave blank**

   Signature: _____ Date: _____

   Parent/Guardian Signature (*if applicable*): _____ Date:_____

   Relationship to individual (*if applicable*): _____

Legal/consent

Client ID: _____

CoSHIE – Frequently Asked Questions

What is CoSHIE?

CoSHIE is a free state system that delivers your information to trusted partners that can help you with food, housing, transportation and similar needs.

How is my information going to be used?

Your information is only used to help you get services you want. For example, if you need help with housing or getting to appointments, CoSHIE partners can use your information to help you get those supports. CoSHIE doesn't keep your information. It just makes sure your information gets to the right people who can help.

What do I get?

With CoSHIE, your information works for you. You don't have to keep retelling your story — your care team already knows what you need. That means less paperwork, fewer repeated questions, and quicker access to support. Signing up is free and easy, and it helps unlock resources and services that can make daily life a little smoother.

What if I change my mind after I sign up?

You can change your mind at any time. If you decide to stop sharing, CoSHIE will no longer share your information going forward. Anything already shared will stay with the organizations that received it, but no new information will be sent. If you want to rejoin later, you can sign up again. It's always your choice, and it's always free and easy. Visit oehi.colorado.gov/shie to stop sharing information**.**

What if I choose not to sign up?

That's okay — your care will still continue. You'll still see your providers and get help. The difference is that it may take longer for your care team to connect you with extra services, and you might have to repeat your story more often. If you change your mind later, you can sign up at any time. It's free and easy to do. Visit oehi.colorado.gov/shie to sign up**.**

Is my information safe?

Yes, your information is safe. CoSHIE shares it only with trusted partners who must use your information to help you, not for anything else. Think of CoSHIE like a mail carrier: it delivers your information to the right place and doesn't keep a copy. Your information stays in the system for only a short time before moving on, and it's protected with strong safeguards to keep it private.

Who runs the CoSHIE?

The Colorado Department of Healthcare Policy & Financing (HCPF), which runs Health First Colorado, and the Colorado Office of eHealth Innovation (OeHI) operate CoSHIE. Government funding supports this system to help Coloradans. More information is available on the OeHI website, **oehi.colorado.gov/shie.**

Who should I contact for more information?

You can contact the CoSHIE Help Desk for any questions you have.

Client ID: _____

Client Medical Information

Client Name: _____ Client Date of Birth: _____

1. **Please answer the following questions related to your health:**
   - When was your last annual physical exam?
     - ☐ Never ☐ 0-12 Months ☐ 1-5 years ☐ 5+ years ☐ Unknown
   - When was your last dental appointment?
     - ☐ Never ☐ 0-12 Months ☐ 1-5 years ☐ 5+ years ☐ Unknown
   - Do you wear hearing aids? ☐ Yes ☐ No
   - Do you wear glasses or contacts? ☐ Yes ☐ No
   - Are your immunizations up to date? ☐ Yes ☐ No ☐ Unknown
   - Are you currently pregnant? ☐ Yes ☐ No ☐ N/A

2. **Please list all prescribed or frequently used over the counter medications:**

	Name	Dosage	Frequency	Prescribed by
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

3. **Provider information:**

   Name of Primary Care Physician/Agency: _____

   Phone number: _____

   Name of Pharmacy: _____

Client or Parent/Legal Guardian Signature: _____ Date: _____

#160 / Medical History / Medical

Client ID: _____

RELEASE OF INFORMATION OR AUTHORIZATION FOR 42 C.F.R. PART 2

I, _____ _____ /_____ /_____
Consumer's First Name Middle Initial Last Name *Consumer's Date of Birth*

Authorize the AllHealth Network to obtain information from, and share information with: My identified health insurance company including Medicaid or Medicare.

Information related to Substance Abuse may include:

- Assessment/Diagnosis/Family History
- Treatment Summary and Recommendations
- Psychological Testing/Consultation
- Medical Information/Medications Prescribed
- Drug/Alcohol History and Treatment
- Service Plans

☐ **By checking this box,** I hereby authorize AllHealth Network to disclose my health information, including information related to my treatment for alcohol and/or drug abuse, for the purpose of AllHealth Network submitting claims for payment to my insurance company. (Services may not be conditioned or refused if consumer refuses to sign.)

I understand that information to be released/authorized may include information regarding the following condition(s):

Drug Abuse
Alcoholism or Alcohol Abuse
Psychiatric Conditions/Treatment
HIV/Auto Immune Deficiency Syndrome (AIDS)

I understand that AllHealth Network may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not.

If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42 C.F.R. Part 2.

I understand that I may revoke this release/authorization at any time by giving verbal or written notice to AllHealth Network, except to the extent that action has already been taken in reliance on it. Without such revocation, this release/authorization will expire on _____ / _____ / _____ ,
or if left blank, two years from the date of my signature, or as of the action or event of _____
_____.

I understand that I have the right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

_____ _____
Signature of Consumer/Parent/Legal Representative *Relationship to Consumer*

_____ /_____ /_____ _____
Date *Witness*

#200/ SUD- ROI / SC-ROI

Revised November 2022

Client ID: _____

Notice of Client Rights

As a client at AllHealth Network, you have certain rights. It is important you know what those rights are. If you have questions about these rights, please call 303-347-6405. We want to help you understand your rights. We want to make sure you are being treated fairly.

You have the right to:

- Be treated with respect and due consideration for your dignity and privacy
- Be treated equally without discrimination based on race, color, national origin, religion, age, sex, gender, financial status, political affiliation, sexual orientation, or disability
- Get culturally appropriate and competent services from AllHealth Network providers
- Get services from a provider who speaks your language or get interpretation services in any language needed
- Get information in a way that you can easily understand
- Be a part of discussions about what you need and make decisions about your care with your providers
- Have an individual plan for services and be a part of developing it.
- Get a full explanation from us about:
  - You or your child's diagnosis and condition,
  - Different kinds of treatment that may be available,
  - What treatment and/or medication might work best, and
  - What you can expect
- Be free from any form of restraint or seclusion used as a means of convincing you to do something you may not want to do, as a punishment, or for convenience of staff
- Know about any fees you may be charged
- To request a change in the people providing your care.
- Be notified quickly of any changes in services or providers
- Get written information on advance medical directives
- Get a second opinion if you have a question or disagreement about your treatment
- Make a grievance (complaint) about your treatment to AllHealth Network without retaliation. You may choose someone else to represent you when you make a complaint.
- Get information about and help with grievances and appeals
- Have an independent advocate help with any questions, problems, or concerns about the mental health system
- Express an opinion about AllHealth Network services to state agencies, legislative bodies, or the media without your services being affected
- Exercise your rights without any change in the way AllHealth Network providers treat you
- Have your privacy respected. Your personal information can only be released to others when you give your permission or when allowed by law. There are exceptions to this that can be found in the Notice of Privacy Practices.
- Know about the records kept on you while you are in treatment and who may have access to your records
- Get copies of your treatment records and service plans and ask AllHealth Network to change your records if you believe they are incorrect or incomplete
- To know the names, professional status, and experience of the staff that are providing services
- Any other rights guaranteed by statute or regulation (the law)
- To receive services in the least restrictive environment, as allowable
- To know that sexual intimacy in a professional relationship is never appropriate. You should report this to the Department of Regulatory Agencies.
- Have an advance directive and have AllHealth Network comply with it.

Client ID: _____

Additional Rights

If you are receiving treatment at AllHealth Network's Acute Treatment Unit (ATU) or Crisis Stabilization Unit (CSU), you have these additional rights:

- To receive and send mail; no incoming or outgoing mail will be opened, delayed, held, or censored by AllHealth Network
- To have access to letter writing materials including postage, and to have staff members help write and mail letters
- To have access to a telephone, both to make and receive calls in privacy
- To be able to meet with visitors
- To wear your own clothing that meets safety guidelines for the unit
- To refuse to take psychiatric medications, unless medications are ordered for you by the court or you are an imminent danger to self or others
- To not be fingerprinted unless required by law
- To refuse to be photographed except for facility identification and the administrative purposes of the facility
- To receive 24 hour notice before being transferred to another facility unless there is an emergency, and to have AllHealth Network notify someone of your choosing about the transfer
- To retain and consult with an attorney
- To have the opportunity to vote in primary and general elections

How to Complain about your Services

If you are unhappy with AllHealth Network you can talk to a Client Representative at AllHealth Network. We will try to make things better and help you fix any issues you may have. To file a complaint, please call 303-347-6405. We will call you back within 2 business days. We will work hard to resolve your complaint quickly; you will hear from us again in no more than 15 working days from the date you complained.
To make a complaint in writing, please contact:

AllHealth Network Attn: Client Representative
155 Inverness Dr. W.; Suite 200
Englewood, CO 80112

Other Important Numbers

You have the right to contact people outside AllHealth Network about your concerns. These are some places you may wish to contact.

- Department of Regulatory Agencies (DORA) at 303-894-7855 or 800-886-7675 or www.colorado.gov/dora or at 1560 Broadway Suite 110, Denver, CO 80202
- Signal at 303-639-9320 or 6130 Greenwood Plaza Blvd., Greenwood Village, CO 80111
- Behavioral Health Administration: 303-866-7400 or 710 S. Ash St. Suite C140, Denver, CO 80243.
- Access Behavioral Health Care at 303-751-9030 or 1-800-984-9133
- Department of Health Care Policy and Financing (HCPF) by calling (303) 866-3513, toll-free at 1 (800) 221-3943, or at 1570 Grant Street, Denver, Colorado 80203
- Ombudsman for Medicaid Managed Care at (303) 830-3560, toll-free at 1 (877) 435-7123, or TTY at 1 (888) 876-8864
- Your insurance company (often complaints can be accepted online or by calling the member services department)

NOTICE OF PRIVACY RIGHTS

Client ID: _____

THIS NOTICE DISCLOSES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLSOED AND HOW YOU CAN GET ACCESS TO THIS INFORAMTION- PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, AllHealth Network will obtain, record and use mental health and medical information about you that is protected health information (PHI). This information is confidential and will not be used or disclosed without your written authorization.

I. **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)**

a. **General Uses and Disclosures Not Requiring the Client's Consent**

1) ***Treatment***. Refers to coordination and management of your medical and mental health care and related services by any provider. AllHealth Network staff involved with your care may use your information to plan your treatment and make sure the most appropriate methods are being used to help you.
2) ***Payment*.** Activities we conduct to obtain to provide reimbursement related to your mental health and medical care. We will use your information for AllHealth Network financial purposes which may include information that identifies you and details of your treatment for bills we send to you and claims we send to your insurance company, other payer, or the State of Colorado Medicaid program.
3) ***Healthcare operations***. Refers to activities by AllHealth Network having to do with regular administrative functions. We may use your health information to monitor service quality, staff training, medical chart reviews, audits, licensing, and other purposes directly related to how we run our business.
4) ***Contacting the client.*** AllHealth Network may contact you to remind you of appointments and tell you about other treatments and services that may help you.
5) ***Required by law.*** AllHealth Network will disclose PHI when required by law in any of the following situations (but not limited to):
    1. Reporting child abuse or neglect
    2. Court ordered
    3. Legal duty to warn or take action regarding imminent danger to others
    4. When client is a danger to self or others or gravely disabled
    5. When required to report certain communicable diseases and certain injuries
    6. When a coroner is investigating the client's death
6) ***Health oversight activities.*** AllHealth Network will disclose PHI to health oversight agencies as authorized by law and necessary for the oversight of any of the following:

1. The health care system *(insurers, doctors, hospitals, pharmacies, etc.)*
2. Government health care benefit programs *(Medicare, Medicaid, etc.)*
3. Regulatory programs *(Drug Enforcement Agency, State Medical Licensing, etc.)*
4. To determine compliance with program standards.

7) ***Crimes on the premises or observed by staff***. Crimes that are observed by AllHealth Network staff, directed toward staff, or that occur on the Network's premises, will be reported to law enforcement.
8) ***Business associates***. Some of the functions of AllHealth Network are provided by contracts we have with other businesses. PHI will be provided to these businesses to perform tasks directly related to AllHealth Network client treatment. These businesses who work with AllHealth Network must enter into an agreement with AllHealth Network that they will maintain the privacy of your PHI.
9) ***Research***. The Network may use or disclose PHI for research purposes.
10) ***Involuntary clients***. To provide and coordinate the care of clients being treated involuntarily, PHI will be shared with other providers, legal offices, and others as the law allows.
11) ***Family members***. Except for certain minors, incompetency or involuntary clients, PHI cannot be disclosed to family members without the client's consent. If family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, PHI may be disclosed in the course of that discussion. However, if the client objects, PHI will not be disclosed. Both parents of divorced children, regardless of awarded decision making, will have access to the child's record unless this action is specifically barred by a court order.
12) ***Fundraising***. AllHealth Network may contact clients as part of its fundraising activities.

13) ***Emergencies***. In life threatening emergencies, AllHealth Network will disclose PHI necessary to avoid harm or death.
14) **CORHIO Participation**. AllHealth Network endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers to more effectively that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. More information about CORHIO can be found at www.CORHIO.org

b. **Client Authorization or Release of Information**. AllHealth Network may not use or disclose your PHI in any way, other than those allowable by law, without a signed authorization or release of information from you. The authorization or release may be revoked by written request or documented verbal communication with you. The revocation will apply upon receipt of notice in writing unless AllHealth Network has already taken care on a verbal order.

II. **YOUR RIGHTS AS A CLIENT**

a. **Access to Protected Health Information (PHI)**. Subject to certain limitations, you have the right to inspect and obtain a copy of PHI contained in your legal medical record. To make a request, ask a AllHealth Network staff for the appropriate form or by calling the HIM team at 303-723-4270. Certain limitations do apply, should you be denied part of your record and would you like to appeal that decision, please contact the Privacy Officer at 720-707-6336.

b. **Amendment of Your Record**. You have the right to request that AllHealth Network amend (revise/correct) your PHI. It is not required to amend PHI if it is determined that the record is accurate and complete. There are other exceptions. Additional information will be provided to you at the time of your request, along with information about the appeal process available to you. To make a request, ask AllHealth Network staff for the appropriate form.

c. **Accounting of Disclosures**. You have the right to receive a list of disclosures AllHealth Network has made regarding your PHI in the 6 years prior to the date of the request. It does not include disclosures for the following:

1) Treatment
2) Payment
3) Health care operations
4) Disclosures made pursuant to a HIPAA-compliant authorization.
5) Disclosures made before April 14, 2003.

There may be other exceptions that will be provided to you should you request an accounting, by asking AllHealth Network staff for a request form.

d. **Additional restrictions**. You have the right to request additional restrictions regarding the use or disclosure of your PHI. However, AllHealth Network does not have to agree with the request. There are certain limits to any restriction. These can be explained to you at the time of your request. To make a request, ask AllHealth Network staff for the appropriate form.

e. **Alternative Means of Receiving Confidential Communications**. You have the right to request that you receive communication of PHI from AllHealth Network by other means or at other locations. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask AllHealth Network staff for the appropriate form.

f. **Copy of this Notice**. You have the right to obtain another copy of this Notice upon request.

Client ID: _____

III. **ADDITIONAL INFORMATION**

a. **Privacy Laws**. AllHealth Network is required by state and federal laws to maintain the privacy of PHI. AllHealth Network is also required by law to provide clients with notice of its legal duties and privacy practices regarding PHI.

b. **Terms of the Notice and Changes to the Notice**. AllHealth Network is required to follow the terms of this Notice and reserves the right to change the terms of its Noice and make the new provisions effective for all PHI that it maintains. When the Notice is revised, it will be posted at AllHealth Network sites and will be available upon request.

c. **Breach Notification**. The Network is required to notify you following an illegal release of your Protected Health Information.

d. **Complaints Regarding Privacy Rights**. If you believe AllHealth Network has violated your privacy rights, you have the right to report this to AllHealth Network management by calling the AllHealth Network Privacy Officer at 720-707-6336. You also have the right to report this to the US Secretary of Health & Human Services by sending your written complaint to:

Office of Civil Rights
US Department of Health & Human Services
200 Independence Ave. SW Room 509F HHH
Washington, D.C. 20201
It is the policy of Allhealth Network that there will be no retaliation if you file a complaint.

e. **Additional information**. For more information about your privacy rights at AllHealth Network, please call our Privacy Officer at 720-707-6336.

f. **Effective date**. This notice is effective May 24th, 2024.

IV. **CONFIDENTIALITY OF ALCOHOL AND DRUG USE CLIENT INFORMATION**

Federal law 42 C.F.R. Part 2 protects the confidentiality of alcohol and drug use client records maintained by AllHealth Network and these records may not be released without your written consent unless:

1. The clients consents in writing, OR
2. The disclosure is allowed by a court order, OR
3. The disclosure made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, OR
4. The client commits to threatens to commit a crime either at AllHealth Network or against any person who works for AllHealth Network.

Only a single consent is needed to allow for all future uses and disclosures for treatment, payment and health care operations.

Violation of the federal law and regulations by AllHealth Network is a crime. Suspected violations may be reported to the United States Attorney in the District of Colorado.

Federal law and regulations do not protect any information about suspected child abuse or neglect being reported under Colorado Law to appropriate sate or local authorities.