COMPASS Health

CONSENT FOR TREATMENT

I am consenting to behavioral health treatment at Compass Health and will participate in treatment planning. I understand that my individual needs will be matched with the appropriate type of care and services.

I understand that I can access crisis response services 24 hours a day, 7 days a week by calling 1-800-584-3578.

I understand that Compass Health uses medication monitoring through Aegis and that I will be asked to provide a urine specimen to monitor the presence of the medications I take at the first visit with a doctor or nurse practitioner and at scheduled intervals during the year or when medications change. These results will become part of my medical record and are subject to the same privacy practices as any other part of my medical record.

I understand that Compass Health has the ability to provide telehealth services. The portal that is used may send communications, including text messages, to the cell phone or email address I provide. These communications may include a HIPAA consent, and appointment reminders. Face to face remote appointments will take place through the same, HIPAA compliant portal. It is my responsibility to protect my privacy and confidentiality by choosing a private location for remote appointments.

I understand that Compass Health staff work collaboratively, and that information about me and my treatment needs may be shared between staff members. This information will only be shared when necessary and appropriate based on each staff person's job. Compass Health staff share information for purposes of coordinating care, receiving consultation, or other reasons related to treatment, payment, and operations.

Applicable Notices of Privacy Practices are posted and copies are available upon request. The Notice of Privacy Practices explains your rights in accordance with RCW 70.02.050, 71.05.390, 71.05.630, CFR 42 part 2, and the Health Insurance Portability and Accountability Act (HIPAA).

I have received and understand the orientation packet material:

- ☐ Welcome Packet
- ☐ Client Rights
- ☐ Clinician Disclosure Statement (available at assessment)
- ☐ Financial Agreement
- ☐ Advanced Directives for Psychiatric Care
- ☐ Materials provided in alternate format/language (*office use only*)

Do any of the following apply to you (or your child, if you are requesting services for your child)? If yes, you are asked to please provide a copy of the document.

- ☐ Yes ☐ No Letters of Guardianship
- ☐ Yes ☐ No Powers of Attorney
- ☐ Yes ☐ No Advanced Directives for Psychiatric Care
- ☐ Yes ☐ No Parenting Plan

Are you:

- Under department of corrections (DOC) supervision? ☐ Yes ☐ No
- Under civil or criminal court ordered mental health or chemical dependency treatment? ☐ Yes ☐ No
- On a Less Restrictive Alternative or Conditional Release court order? ☐ Yes ☐ No

If you answered yes to any of the above questions, is there a court order exempting you from reporting requirements?

☐ Yes ☐ No If so, a copy of the court order must be included in the record - please provide a copy.

Client Name/ID/DOB *(or affix label)*

ATTENDANCE AND ENGAGEMENT IN SERVICES

Thank you for choosing Compass Health for your behavioral healthcare services. We want to ensure we are meeting your needs and helping you achieve your goals for wellness and recovery. We are here to help you be successful and reach your goals.

What you can expect from us...

- Provide a welcoming, friendly, professional and respectful environment.
- Be on time for your scheduled appointments.
- Create a therapeutic relationship with the foundation of trust and respect.
- Be clear about the therapeutic process, attendance expectations and problem solve barriers to treatment.
- Be responsive to your requests and follow through in a reasonable amount of time.

What we expect from you...

- Be friendly and respectful of staff and other clients.
- Keep all scheduled appointments. If you need to reschedule an appointment, please call at least one full business day in advance of the appointment.
- Actively participate in your treatment to achieve your identified goals for recovery.

Regular attendance and engagement in the treatment process is key. We expect individuals to keep all scheduled appointments and we have a no show/cancellation policy. An alternative scheduling plan will be put in place if you have 2 no-show/late cancellation events within a 60-day period. Clients who repeatedly cancel, even with notice, may also be provided with an alternative scheduling plan.
The alternative scheduling plan means you will not be given a scheduled appointment in advance, but will be offered other options.

ELECTRONIC HEALTH RECORD

I authorize Compass Health to include my health care information, including all records of my substance use disorder treatment (if any) in the Compass Health electronic health record (Credible).

I understand that my substance use disorder treatment records may be available to Compass Health staff who are not specifically or exclusively assigned to the substance use disorder treatment program. Compass Health policy prohibits all employees from accessing records except as needed for their job functions. My information may be accessed by Compass Health staff outside of the substance use disorder program only as needed for purposes of treatment, payment, or healthcare operations.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

If I have particular concerns about who can access my medical record, I can discuss these concerns with my clinician, the program manager, or the Compass Health Quality Department. I have the right to request that access to my record be restricted, however I understand that my primary clinician(s) cannot be restricted from viewing my Compass Health record.

OUT OF COUNTY SERVICES

If I am requesting services outside my county of residence. I understand that some services that would be typically be available to Compass clients may not be available to me, and other services may be limited or impacted by this decision.
For example:
Outreach Services (home visits) by the primary clinician/team are not available outside the county. For example if you live in Skagit County and receive services in Snohomish County, your Snohomish County clinician will not perform outreach services to Skagit County. Crisis services will still be available to you in your county of residence, but these services will be from a different clinical team.

Community support and coordination of care may be impacted. Most clinicians are familiar with local resources but may be unfamiliar with resources available in other counties, limiting their ability to assist you with referrals or to connect with other supports you may be involved with such as schools, doctors offices, and DSHS.

Transportation is your responsibility. Because you are receiving services out of county, transportation that might otherwise have been available to you may not be (for example, bus service, Medicaid Transportation, etc). This can have an impact on your ability to make and keep appointments.

Client Name/ID/DOB *(or affix label)*

I have been asked to receive behavioral health services through the telehealth system. I understand the use of the video conferencing equipment is a method of health care delivery in which services are delivered to an individual by a provider at a site other than where the individual is located. I understand that I may receive health care services through the telehealth system. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that I will communicate through the telehealth system with a health care provider located at another location. I understand there are no additional charges or fees for clinical services I will receive through the use of the telehealth system. I understand that my participation in telehealth is voluntary and I may refuse to participate or decide to stop participation at any time. I have been informed of the potential consequences of my refusal to participate or stop participation in telehealth services.

I understand that my privacy and confidentiality will be protected. I also understand communication through the telehealth system occurs over secure telecommunications lines dedicated for this purpose. I understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. I understand no video or audio recording of the service(s) will be made without my consent. When I am receiving services through the telehealth system, I understand I will be notified as to who is in the room at the remote site.

I understand that the health care providers at both my location (if applicable) and the remote video site may have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

Additionally, as part of Compass Health telehealth services, Compass Health has the ability to send information via e-mail and text messaging for non-urgent matters through a secured mechanism. You may receive e-mail or text messages from your clinician for items such as: a request that you call your clinician, or documents related to your treatment such as a consent to treatment or client rights. Please only respond to Compass Health emails via the 'reply' feature within the secure email or via the secure texting App for text messages. Email and texting should **not** be used in emergencies or for any urgent communication. Compass Health cannot and does not guarantee the privacy or security of any messages being sent by e-mail or text messaging. Routine reminder phone calls and/or text messages, when chosen by you, are not covered by this consent. It is your responsibility to inform Compass Health of your current email address and telephone number and of any changes to your contact information.

I may access Compass Health information about my (or my child's) care through the client portal of the Compass Health Electronic Health Record. The client portal does not contain my (my child's) entire medical record. If I would like access to the client portal, I can request access from my clinician.

I have read this document and I hereby consent to participate in behavioral health services through the telehealth system including electronic correspondence under the terms described above. I understand this document will become a part of my medical record.

☐ By checking this box, you are choosing to opt out of our telehealth services

FINANCIAL AGREEMENT

I authorize release of medical information necessary to process my claim.

I agree to the assignment of all insurance payments to Compass Health, PO Box 3810, Everett WA 98213. I authorize my insurance carrier to pay benefits directly to the agency. I agree to forward any insurance payments I might receive directly to the agency. Insurance does not guarantee benefits. I am responsible for fees not covered by insurance.

I understand that Compass Health may provide audio-only telehealth services, and that these services will be billed to my insurance or to me if not covered by insurance.

It is my responsibility to inform the agency of any changes in my financial status.

I understand that my portion of the fee is due at the time of service and agree to pay promptly all fees for which I am responsible; failure to do so may result in termination of services.

If I lose Medicaid while in services with Compass Health, I understand I am fully responsible for all fees incurred, and that income verification may be required.

Client Name/ID/DOB *(or affix label)*

A copy of Compass Health's fee schedule is posted at the office and is available upon request. I understand that these fees are subject to change based upon the revision of the fee schedule.
I understand that I may be charged a NO-SHOW FEE for missed or canceled appointments unless 24 hours' notice is given.

RELEASE OF INFORMATION / AUTHORIZATION OF INSURANCE BENEFITS

I authorize COMPASS HEALTH to disclose all or any part of my medical records, including mental health and alcohol and drug abuse records, to representatives of my insurance companies in order to process this claim.
For Substance Use Disorder Treatment:
I authorize release to my insurance provider, or payer for my SUD services, listed here.

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina Healthcare
- United Healthcare
- North Sound Behavioral Health Administrative Service Organization
- Other:_____
- Other:_____

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service.

I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

I have read, been offered a copy of and agree to the above conditions. Unpaid fees are subject to collection.

Client Signature	Printed Name	Date
Parent / Guardian Signature	Printed Name	Date
Clinician Signature / Degree / Specialty		Da

Client Name/ID/DOB *(or affix label)*

THIS SECTION FOR KINSHIP CAREGIVERS ONLY

It is the intent of the Washington State Legislature to assist kinship caregivers in accessing appropriate medical care to meet the needs of a child in their care by permitting such responsible adults who are providing care to a child to give informed consent to medical care.

Compass Health, in an effort to reduce barriers to mental health care for children, will accept the attestation of an adult caregiver that they are the responsible adult relative providing informed consent to mental health treatment on behalf of the child, so long as we do not have actual notice that this claim is untrue.

Compass Health will NOT accept the consent of the person named in this Declaration if consent was or is refused by any of the following:

- The appointed guardian or legal custodian of the minor;
- A person authorized by the court to consent to medical care for a child in out of home placement (i.e. DCFS);
- The minor's parents;
- The individual, if any, to whom the minors parent has given a signed authorization to make health care decisions for the minor;
- A minor who is capable of giving their own consent (i.e. age 13 - 17).

Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care
Use of this declaration is authorized by RCW 7.70.065

Minor's First Name: _____
Minor's Last Name: _____
Minor's DOB: _____
Caregiver's Name: _____
Caregiver's Address: _____
Caregiver's DOB: _____
Caregiver's Relationship to Minor (grandparent, aunt/uncle, etc): _____

THIS DECLARATION IS ONLY VALID FOR SIX MONTHS FROM THE DATE SIGNED

General Notices:

1. This Declaration does not affect the rights of the minors parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor. It also does not affect the rights of the minor to consent to his/her own medical care where authorized by law.
2. A person who relies on this Declaration has no obligation to make further investigation or inquiry beyond what is said on the Declaration form if the provider does not have actual notice of the falsity of the statements made in the Declaration.
3. A health care provider may, but is not required to, request additional documentation of a persons claimed status as being a relative responsible for the health care of the minor patient.
4. This Declaration is ONLY valid for six months from the date above. If necessary, a caregiver may sign below to renew the declaration after its expiration.

I declare that I am 18 years of age or older and I am a relative responsible for the health care of the minor named above. I declare under penalty of perjury under the laws of the State of Washington that the above is true and correct.

_____	_____	_____
Client Signature	Printed Name	Date
_____	_____	_____
Parent / Guardian Signature	Printed Name	Date
_____		_____
Clinician Signature / Degree / Specialty		Date

Client Name/ID/DOB *(or affix label)*

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