VOA Alaska

VOA Alaska Registration

Name of person completing this form: _____

Preferred contact information? ☐ Phone ☐ Text ☐ Email **Text reminders okay?** ☐ Yes ☐ No

Phone: _____ **Email:** _____

Are you the legal guardian of the youth being referred to services? ☐ Yes ☐ No

Relationship to client? _____

Any custody information/arrangement VOA Alaska needs to be aware of? ☐ Yes *(Explain Below)* ☐ No

_____

_____

Who referred you to VOA Alaska? ☐ Self ☐ Family/Friend ☐ DJJ ☐ OCS ☐ Hospital/Primary Care
☐ Other Behavioral Health Provider ☐ Shelter ☐ Houseless Coordinated Entry
☐ Referral Agency (like 211) ☐ Tribal Health Orgs & Corporations ☐ School

Can you explain in a brief sentence below what VOA Alaska can help support you with?

_____

_____

To determine priority placement criteria, is the youth you are referring (mark any that apply):

☐ Using substances intravenously ☐ Pregnant ☐ Experiencing Houselessness
☐ Involved with Office of Children Services ☐ Involved with Division of Juvenile Justice

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Did you provide name, date of birth, and gender information to VOA Alaska staff already? ☐ Yes ☐ No

Name of youth being referred for services: _____

Preferred name: _____ **Date of Birth:** _____

Physical Address: _____

Gender: ☐ Male ☐ Female ☐ Gender Diverse (please identify): _____

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Primary Insurance: _____ **Insurance ID:** _____

Insurance Address: _____

Name of Subscriber: _____ **Group Number:** _____

DOB of Subscriber: _____ **SSN of Subscriber:** ____ / ____ / _____

Subscribers Mailing Address: _____

Household Income: ☐ Below $20,000 ☐ $20,000 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000 or more

As a non-profit, we provide services despite one's ability to pay. Are you interested in discussing financial assistance options? ☐ Yes ☐ No

VOA Alaska

New Client Agreement

Authorization of Medical Benefits and Financial Responsibility

I authorize Volunteers of America Alaska to submit claims to my health plan or insurance company, from the onset of treatment, on my behalf and in the name of the patient named below. I assign to Volunteers of America Alaska insurance benefits otherwise payable to me. This authorization shall remain in effect until revoked.

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Volunteers of America Alaska for any charges not covered by health care benefits. I am responsible for the entire bill or balance of the bill as determined by Volunteers of America Alaska and/or my health plan or insurance company if the submitted claims or any part of them are denied for payment as not medically necessary or non-covered. It is my responsibility to notify Volunteers of America Alaska of any changes in my health care coverage.

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for services received.

I also understand that **I may apply for a sliding fee discount** on any patient balance by providing Volunteers of America Alaska with either of the income documents listed at the bottom of this page.

Client Initials_____ **Guardian initials** _____

Client Consents

Consents to Treatment

- I consent to treatment at VOA Alaska. This authorization and consent are given in recognition that I have been informed of and agree to comply with all rules and conditions while I am a client with VOA Alaska's behavioral health treatment program. My agreement is indicated by my signature below.
- I understand that my consent for behavioral health treatment services is voluntary and may be withdrawn at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
- I further understand that any changes in my assessment and recommendations for duration of treatment and level of care will be discussed with me prior to such changes becoming effective and will be subject to my approval.
- I understand that developing a treatment plan with my counselor and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
- I understand that VOA Alaska utilizes an interdisciplinary clinical treatment team, for ongoing clinical input and decision making. This team could include both a contracted Psychologist and a contracted Psychiatrist.
- I understand that VOA Alaska uses interns during the course of treatment. These interns may provide various services under supervision from a trained counselor as indicated in VOA Alaska's policies and procedures.
- I authorize the approved Volunteers of America Alaska staff to provide transport to and from work, school, appointments, individual sessions, and any other places necessary for continued care.

VOA Alaska

Telemed Consents

- I hereby agree to receive behavioral health care services through telemedicine/telehealth. I understand the rendering provider is located in another location, and that location may not necessarily be at the usual office setting. A telemedicine/telehealth service means that my visit with a provider at the distant site will happen by using special audiovisual application (like Zoom) or by telephone if Zoom is not possible. As a last resort, applications like email or text may be utilized.

I understand that:

- I consent to contact 911 or go to the nearest emergency room if I am experiencing a crisis emergency.
- I consent that I will only communicate through a device I know is secure, i.e. wherein confidentiality can be ensured. I will go to a private room. If a private room is not possible, I will not have the communication on speaker unless it is a family session and only the family members are present. I will fully exit all online counseling sessions once ended.
- If we are unable to connect or are disconnected during a session due to a technological breakdown, I will try to reconnect within 10 minutes. If reconnection is not possible, I will call to schedule a new session time.
- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- If I decline telehealth services, Volunteers of America Alaska can provide in-person services only once COVID-19 emergency health protocols are lifted per agency policy.
- The same confidentiality protections that apply to my other health care services also apply to the telehealth service.
- I will have access to all medical information resulting from the telehealth service as provided by law.
- I will be informed of all people who will be present at all sites during my telehealth service and I may exclude anyone from any site during my telehealth service. I have read this document carefully, and my questions have been answered to my satisfaction. I have been advised of any potential risks, consequences and benefits of telehealth. This consent is valid unless revoked.

Acknowledgment of Client Rights and Program Expectations

- I have received and reviewed the VOA Program Handbook. I am also aware that I can access a copy of the handbook on the VOA Alaska website at any time or I can request a replacement at the VOA front desk.
- I understand that the agency does not use seclusion or restraint as part of their nonviolence prevention program.
- I understand the VOA grievance policy as outlined in the Program Handbook.
- I agree to the program rules as described in the Program Handbook.
- If enrolled in a substance use treatment program, I agree to remain abstinent from the use of any mood-altering chemicals (including alcohol or marijuana) other than those prescribed for me by licensed medical professionals.
- I agree to submit to recognized drug screens conducted either at random or upon request by the program staff. I understand that if these tests indicate the presence of alcohol or drugs for which no acceptable reason can be offered, I may be discharged from the program. I also understand that the results of these drug screens may be shared with other agencies or individuals as required by law and allowed by any consent forms I have on file.
- VOA Alaska reserves the right to refuse or reschedule an assessment appointment if there is clinical justification not to proceed.

VOA Alaska

Safety and Emergency Care

- I acknowledge and understand that no promise or guarantees have been made to me regarding the outcome of my treatment by VOA Alaska and do hereby absolve VOA from liability in the event my treatment is unsuccessful.
- I understand that, unless I am in-residence with the ARCH program, VOA does not administer, maintain, or control my prescription medication in any manner. If you need to take medications during treatment time, you are responsible for your own medication administration. Such administration is not appropriate in a group setting and should be performed in private.
- I understand that I will participate in emergency preparedness drills as a part of the agency's health and safety program.
- I hereby give my permission to be given medical treatment in case of an accident, injury, or illness. I hereby release Volunteers of America Alaska and its representatives from any liability arising from an emergency in which it is deemed necessary to pursue medical treatment in the event of an accident, injury, or illness. Volunteers of America Alaska consider the client's physical health maintenance to be an integral element in a successful substance-free lifestyle. It is the family's responsibility to ensure annual physical examination and that the ongoing medical needs are being provided to the client.

Information and Privacy Policies

- I hereby authorize VOA to contact me by mail, telephone or in person after my discharge or graduation as follow-up is an integral part of my overall treatment.
- I authorize Volunteers of America Alaska to contact me to request to utilize my protected health information for marketing, fundraising, and opportunities to raise awareness of the impact of VOA Alaska's services. I understand I have the right to opt out of these communications at any time.
- I understand and consent to the use of all electronic communication, text messaging, and email and that they allhave potential security risks.
- I understand I may acquire information regarding other clients which must be kept confidential and that there are legal penalties (fines and prison sentences possible) for the unauthorized disclosure of this information.
- I understand that VOA may exchange my information as appropriate to the regular order of business and that coordinating with partners is not considered a disclosure. Such internal exchanges include, but are not limited to:
    - Sharing necessary information with Millennium Health, the lab that performs our substance screenings to ensure accurate test results.
    - Sharing information with the Department of Behavioral Health and other reviewing bodies to ensure quality of care and VOA licensure.
    - Sharing information as needed to obtain legal or financial services.
    - Coordinating care with another medical facility, if needed.
    - Coordinating with qualified entity under an appropriate business associate agreement.

VOA Alaska

Confidentiality of Alcohol and Drug Abuse Patient Records

Federal Law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by Volunteers of America. The Volunteers of America of Alaska may not disclose to a person outside this agency that you attend the program, or disclose any information identifying you as an alcohol or drug abuser unless:

1. Your consent in writing.
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
4. Federal Law and regulations do not protect any information about a crime committed by a client either at the Volunteers of America of Alaska or against any employee of Volunteers of America of Alaska or about any threat to commit such a crime.
5. Federal Law and regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local authorities.

Violation of the Federal Law and regulations by Volunteers of America of Alaska is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

A copy of the Federal regulations is kept by Volunteers of America. You may ask your counselor to review the regulations if you have any questions. (See 42 CFR Part 2)

* Volunteers of America, Alaska is audited by Division of Family and Youth Services (DFYS), State of Alaska Division of Alcohol and Drug Abuse (ADA) and The Rehabilitation Accreditation Commission (CARF).

Client Initials_____ Guardian initials _____

Notice of Privacy Practices

Acknowledgement of Receipt

Effective April 14, 2003. Policy Attached Below. PLEASE REVIEW CAREFULLY.

The Notice of Privacy Practices describes how Volunteers of America Alaska may use or disclose your protected health information. The example in this Notice is not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Volunteers of America Alaska. Volunteers of America Alaska is required to give you a copy of our Notice of Privacy Practices.

I hereby acknowledge that I received a copy of Volunteers of America Alaska's Notice of Privacy Practices.

ACKNOWLEDGEMENT OF CONFIDENTIALITY REGULATIONS

The undersigned hereby acknowledges and agrees to abide by the Federal Regulations governing the Confidentiality of 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). These regulations prohibit the disclosure or re-disclosure of protected health information in such a way as to compromise the confidentiality and privacy of current program clients, of former program clients, or of those applying for, or otherwise seeking client status. This prohibition includes any disclosure of any protected health information, which may identify an individual, not just alcohol or drug related information.

VOA Alaska

The undersigned specifically acknowledges and agrees to the following prohibition.

This information has been disclosed to you from records protected by Federal Regulations governing Confidentiality of 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. The Federal Regulations prohibit you from making any further disclosure of this information without specific written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2, and HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices and that you have an understanding of the Confidentiality Regulations.

Client Statement:

My signature below indicates that I have read and have had the opportunity to discuss and ask questions about the foregoing "NEW CLIENT AGREEMENT"; that I fully understand the meaning of each point; that I knowingly and voluntarily consent to the terms of each one; and that I have not been under any duress or force nor under the Influence of alcohol or other drugs.

_____ _____

Client Signature Date

Additional Guardian Consents

- I understand, as the guardian(s) not to request any information for court related reason whatsoever, including but not limited to custody issues.
- I understand that the role of the therapist is not to make recommendations to the judge or to express opinions concerning divorce or custody issues.

Guardian Statement:

My signature below indicates that I have read and have had the opportunity to discuss and ask questions about the foregoing "NEW CLIENT AGREEMENT"; that I fully understand the meaning of each point; that I knowingly and voluntarily consent to the terms of each one; and that I have not been under any duress or force nor under the Influence of alcohol or other drugs.

_____ _____

Guardian/Legal Guardian Signature Date

VOA Alaska

Insurance Billing Authorization & Fee Agreement

I, (Client name)_____/ (Date of birth)_____

authorize Volunteers of America-Alaska and the following insurance company(s):

↓	
	Medicaid/Denali KidCare
	Aetna
	Blue Cross
	Cigna
	Moda
	United Healthcare
	Beacon/Value Options
	Other (Must Indicate):

Please indicate ALL insurances that apply

To communicate and disclose to one another the following information verbally, written, and/or facsimile:

➔_____I consent to the access to my client records from Volunteers of America Alaska to obtain:

- My name and other personal identifying information
- Any assessment evaluation results and history
- Date of admission/interpretive summary
- Date of transition/discharge and transition/discharge summary
- Progress note(s)
- Diagnosis
- Treatment plan
- Progress report(s) and compliance
- Toxicology results
- Continuing care plan
- Treatment recommendations

The disclosure of the information in this consent is for the purpose of:

➔_____ processing insurance claims and reviews, obtaining benefits and authorizations

➔_____ I understand the information to be disclosed may include information pertaining to drug/alcohol abuse, treatment, and rehabilitation.

I understand that my records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this *consent automatically expires one year from the earliest date of signature unless otherwise indicated here:*

_____.

(specification of the date, event, or condition upon which this consent expires)

I understand that generally Volunteers of America, Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

CLIENT signature		**GUARDIAN signature**	
Date		**Date**	

VOA Alaska

Confidential Information – Guardian

I, (Client name)_____/ (Date of birth)_____

authorize: Volunteers of America Alaska
2600 Cordova St, #101 (and all VOA-AK locations)
Anchorage, AK 99503
Phone: (907) 279-9640, Fax (907) 276-5489 and

Guardian(s) or Legal Guardian name(s):	Address:	Phone:

To communicate and disclose to one another the following information verbally, written, and/or facsimile:

(Client must indicate each category that applies)

➔	My name and other personal identifying information	➔	Treatment plan
➔	Any assessment evaluation results and history	➔	Progress report(s) and compliance
➔	Date of admission/interpretive summary	➔	Toxicology results
➔	Date of transition/discharge and transition/discharge summary	➔	Continuing care plan
➔	Significant information for screening and treatment	➔	Medical emergencies
➔	Attendance in Treatment	➔	Other:

The disclosure of the information in this consent is for the purpose of:

(Client must indicate each category that applies, and **have at least ONE purpose**)

	Continued treatment		Personal use
	Legal		Guardian participation in treatment
	Other (Must indicate):		

➔_____ I understand that the information to be disclosed may include information pertaining todrug/alcohol abuse, treatment, and rehabilitation.

I understand that my records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this *consent automatically expires one year from earliest date of signature unless otherwise indicated here:*

_____.

(Specification of the date, event, or condition upon which this consent expires)

I understand that generally Volunteers of America Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

CLIENT signature		**GUARDIAN signature**	
Date		**Date**	

VOA Alaska

Consent for the Release of Confidential Information – Other Party

I, (Client name)_____/ (Date of birth)_____

authorize: Volunteers of America Alaska
2600 Cordova St, #101 (and all VOA-AK locations)
Anchorage, AK 99503
Phone: (907) 279-9640, Fax (907) 276-5489 and

Name(s) of other involved parties:	Address (if known)	Phone Number:

To communicate and disclose to one another the following information verbally, written, and/or facsimile:

(Client must indicate each category that applies, categories apply to all named above)

➔	My name and other personal identifying information	➔	Treatment plan
➔	Any assessment evaluation results and history	➔	Progress report(s) and compliance
➔	Date of admission/interpretive summary	➔	Toxicology results
➔	Date of transition/discharge and transition/discharge summary	➔	Continuing care plan
➔	Significant information for screening and treatment	➔	Medical emergencies
➔	Attendance in Treatment	➔	Other:

The disclosure of the information in this consent is for the purpose of:

(Client **MUST** indicate each category that applies, and **have at least ONE purpose**)

	Continued treatment		Personal use
	Legal		Guardian participation in treatment
	Other (Must indicate):		

➔_____ I understand that the information to be disclosed may include information pertaining todrug/alcohol abuse, treatment, and rehabilitation.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this *consent automatically expires one year from earliest date of signature unless otherwise indicated here:*

_____.

(Specification of the date, event, or condition upon which this consent expires)

I understand that generally Volunteers of America Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

CLIENT signature		**GUARDIAN signature**	
Date		**Date**	

VOA Alaska

Consent for the Release of Confidential Information

Volunteers of America-Alaska is committed to providing quality treatment to our clients. It is important that VOA Alaska programs are effective and meet the needs of those we provide services for. To help ensure this VOA conducts follow-up surveys with our clients at intake, three months, discharge, and six- and twelve-months post treatment. The data from these surveys further allow us to make changes and improvements to the ARCH and Assist programs. The surveys will be completed in our facility while clients are in the treatment program. After discharge follow up survey information will be collected by phone or by mailing the survey to the client's home address. Please be assured that confidentiality guidelines will be followed, and information is for program evaluation only.

I have read the above information and I give my consent for Volunteers of America to contact me for follow up surveys, up to 18 months after I leave the program. I give my consent for Volunteers of America to contact my legal guardian for my location if I am unable to be reached after I have left treatment.

I,_____/ _____
Client Name **Date of Birth**

authorize Volunteers of America-Alaska (Assist/ARCH) and to communicate with and disclose to one another the following information verbally, written, and/or facsimile: (**Client MUST** indicate each category that applies).

	My name and other personal identifying information		**My location to include phone number and physical address**

To the following individuals: (Client MUST indicate each category that applies).

	Guardian		**State Social Worker**
	Probation Officer		**Other (must specify):**

The disclosure of the information in this consent is for the purpose of:

(**Client MUST** indicate category that applies)

	Collection of Follow-Up Survey Data

I understand that the information to be disclosed includes information pertaining to drug/alcohol abuse, treatment and rehabilitation._____**(Client MUST indicate consent)**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as upon obtaining 12 month follow up survey.

I understand that generally Volunteers of America, Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Client Signature:		**Guardian Signature:**	
Date:		**Date:**	