Welcome to WMMHC!

Please answer these questions as they apply to the person receiving services. Make sure to print clearly.

Name: _____

First Middle Last (Maiden)

Preferred Name: _____ Suffix: _____

Date: _____ Social Security Number: _____

Legal Guardian (if applicable):_____

Birthdate: _____ Gender: Male / Female / Other (Circle One)

Contact Preference: work/home/cell*/other _____ Contact Phone: _____

Work Telephone: _____ Cell Phone Number*: _____

Email Address*: _____

****We will use your Contact Preference to do Appointment Reminders unless you select otherwise****

Mailing Address: _____

City, State: _____ Zip Code: _____

Physical Address (if different): _____

City of Residence: _____ County of Residence: _____

Prior County of Residence: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Language Preference: _____

Health Insurance Plan: _____

HEALTH INSURANCE

☐ I DO NOT have any health insurance coverage (i.e. Medicaid, Medicare, Private Insurance, etc.)

☐ I DO have health insurance coverage.

Fill out the section below <u>only</u> if you are insured. If you are a tribal member, include enrollment number and address of the IHS office.

Policyholder's Name & Birthdate	Policy Number	Group Number	Insurance Company Name	Who in the household is covered?
Primary:				
Secondary:				

What are your goals for treatment? _____

1. What is your race?

□ White/Caucasian □ Black/African American □ American Indian/Alaskan Native
□ Non-Hispanic □ Asian □ Native Hawaiian/Pacific Islander
□ Hispanic: Check One ⬇ □ More than one race □ Unknown
□ Mexican □ Puerto Rican □ Cuban □ Other

2. What is your marital status? □ Single-Unmarried □ Divorced □ Separated
□ N/A (client is a minor) □ Married □ Widowed □ Other/Unknown

3. Have you ever served in the military? □ YES □ NO Active Combat? □ YES □ NO

Branch: _____ Type of Discharge? _____

Are you eligible for Veteran's assistance? □ YES □ NO

4. Do you receive Social Security?

□ SSI Due to Mental Illness □ SSDI Due to Mental Illness □ None
□ SSI Not Due to Mental Illness □ SSDI Not Due to Mental Illness

5. What is your legal status?

□ Self/None □ Dept. of Child & Family Services □ Guardian
□ Dept. of Corrections □ Parent or Grandparent □ Other
□ Youth Court □ Youth Treatment Court □ Unknown

6. What is your employment status?

□ Full Time □ Retired □ Homemaker/Caregiver
□ Part Time □ Disabled/Unable to work □ Volunteer/unpaid
□ Unemployed but able □ Supported/Sheltered □ No interest in work
□ Student □ Transitional □ Other: _____

7. Are you <u>currently</u> in school?

□ Not in school □ Public K-12 □ Home School
□ Adult Ed/GED □ Vocational School □ Private K-12
□ College Full Time □ College Part Time □ Other: _____

8. How many years of education have you completed?

□ Completed____ Grade □ Completed High School/GED
□ HS Plus 1 Yr College □ HS Plus 2 Yrs College
□ HS Plus 3 Yrs College □ Bachelor's Degree □ Graduate Degree

9. Who referred you here? (Select one)

□ Self □ Hospital Inpatient/ER □ Friend
□ Native American Agency □ Shelter □ Family
□ Non-Psychiatric Physician □ Police □ School
□ Veteran's Administration □ Clergy □ MT State Hospital
□ Treatment Center □ EAP □ Crisis Center
□ Agency for the Elderly □ DDA □ Court
□ Other Mental Health Provider □ Residential Facility □ Agency for Children
□ Physician Name _____ □ Other Mental Health Center
□ Other _____

10. What is your current living situation? (Select one)

□ Living With Family or Friend
□ Living independently
□ Nursing Home
□ Transient
□ Hotel
□ Hospitalized
□ Mental Health Group Home
□ Shelter
□ Psychiatric Res. Treatment Facility
□ Personal Care Home
□ Jail
□ Child Foster Home
□ Adult Foster Home
□ Homeless
□ Non Mental Health Group Home
□ Living Independently with others
□ Therapeutic Foster Care
□ Supported Independent Living

How long have you lived here? _____

12. Are you coming here voluntarily or are you required to receive services?

□ Voluntary □ Forced Voluntary □ Involuntary, Civil □ Involuntary, Criminal

13. Are you on Probation? □ YES □ NO **Are you on Parole?** □ YES □ NO

Name/phone of Probation /Parole Officer: _____

14. Do you currently have a pending DUI, MIP, or Dangerous Drug Charge? □ YES □ NO

Thank you for choosing Western Montana Mental Health Center for your behavioral healthcare needs. A staff member will assist you in getting connected with someone from our clinical team.

CLIENT ACKNOWLEDGMENT
CONSENT, RIGHTS, AND BEHAVIOR

Please initial below to indicate you have received, read, and understood the following:

_____	Consent for Treatment
_____	Demographics are accurate
_____	Client Rights in the State of Montana
_____	Grievance Procedure
_____	General Aggressive Behavior Policy
_____	Smoking and Weapons
_____	Notice of Privacy Practices
_____	For CSCT clients only - Coordination of Care Verification: "According to Administrative rule (37.106.1956.4), Medicaid requires providers to inform youth and their parents about mandatory coordination expectations between CSCT, home support services, and outpatient therapy. I am aware that coordination is required among providers and collaboration is intended to improve outcomes for my child."

Client / Legal Guardian Signature

WMMHC Staff Signature

Date: _____

Date: _____

WESTERN MONTANA
MENTAL HEALTH CENTER

CONTRACT FOR PAYMENT OF SERVICES

Please read this fee agreement carefully and ask for any needed clarification. Please initial at the side of each statement and sign at the bottom.

By initialing each area, I attest that **I UNDERSTAND:**

_____ (initial)
1. I agree to pay any and all costs not paid by a third party payer. These costs may include: my deductible, co-insurance, and/or denial of coverage. If I do not wish to have my services billed to a third party or my insurance becomes inactive during treatment, I will be responsible for **payment in full.**

_____ (initial)
2. If I have Medicaid, I agree to pay any co-pay established by Medicaid. I understand that if my Medicaid becomes inactive during treatment or a service is not covered by Medicaid, I will be responsible for **payment in full.**

_____ (initial)
3. If I have Medicare, I understand that Medicare covers some but not all specific services offered by WMMHC. I agree to pay any co-pay established by Medicare. I understand that, if my Medicare becomes inactive during treatment or a service is not covered by Medicare, I will be responsible for **payment in full.**

_____ (initial)
4. I may qualify for public funding in order to offset a portion of my treatment costs. In order to qualify, I must provide proof of income. **I understand if I do not provide the necessary documentation of eligibility, I will not qualify for public funding and will be responsible for payment in full.**

_____ (initial)
5. In the event I do not qualify for public funding, I may be eligible for sliding scale fee services on the basis of my family income and number of dependents. In order to qualify, I must provide proof of income and complete an application. If I do not wish to provide the necessary documentation, I understand I will not qualify for sliding scale fee services and will be responsible for payment in full.

_____ (initial)
6. If my check is returned, I will be charged a returned check fee of $25.00.

_____ (initial)
7. If my income, situation, insurance coverage, address, or phone number changes, I will immediately notify WMMHC.

_____ (initial)
8. In the event I fail to pay fees as agreed upon, my account may be referred to a collection agency and/or law firm. If the event my account is sent to a collection agency and/or law firm, I will be liable for all costs associated with the collections process, including legal and demand costs.

_____ (initial)
9. I understand WMMHC cannot carry patient balances over 12 months from the last date of service. In signing this agreement, I agree to have the balance of my account paid in full within one year unless other arrangements have been made with the Accounts Receivable Department.

_____ (initial)
10. I understand this contract applies to any and all services rendered by WMMHC program and locations.

Client/Guardian Signature: _____ Date:_____

Client/Guardian Printed Name:_____

Staff Signature:_____ Date:_____

Children and Families Services

Liability Waiver and Release

In consideration of participating in all sports and recreational activities sponsored by Western Montana Mental Health Center/Children and Families Services, including but not limited to biking, river rafting, swimming/water activities, skateboarding, hiking and ropes course or rock climbing.

I _____ agree to assume the known and unknown risks of these recreational opportunities in which my child, _____ participates. I agree to be legally and financially responsible for any injury or property damage resulting from risks inherent in participation in WMMHC sponsored sports and recreational activities including but not limited to risk of falling, drowning, collision with water craft, unknown submerged obstacles, and ingesting water which may not be potable.

_____(initial) I hereby voluntarily release and agree to indemnify Western Montana Mental Health Center from any and all claims, demands and causes of action which are in any way connected with risks inherent in my child's participation in the WMMHC sponsored recreational activities.

By signing this document, you may be waiving your right to a jury trial to hold the provider legally responsible for any injuries or damages resulting from risks inherent in the sport or recreational opportunity or for any injuries or damages your child may suffer due to the provider's ordinary negligence that are the result of the provider's failure to exercise reasonable care.

Dated this _____ day of _____, 202_

Valid through: (date)_____

PRINTED NAME:_____

Signature:_____

To be initialed by parent or legal guardian.

_____WMMHC staff who have provided verification of current auto insurance as required by WMMHC with liability limits of at least $100k/$300k may drive me or my child to and from locations of the programs associated with this waiver.

Consent for Remote Group Sessions

WESTERN MONTANA
MENTAL HEALTH CENTER

To reduce the exposure of our clients and our staff to infectious disease during this highly unusual circumstance related to the COVID-19 pandemic, the provision of our services has moved from an in-person format to a telehealth format.

In addition to one-on-one sessions, group sessions continue to be an important part of your treatment. Western Montana Mental Health Center (WMMHC) will continue to provide group sessions and will need your help to make these sessions confidential for everyone involved. You may choose not to participate in any group sessions and continue to receive one-on-one services only.

We will be able to guarantee a confidential setting on the part of our therapist. We will need to following assurances from you:

- You will find a quiet, confidential and private location to participate in group.
- You will immediately alert the therapist running the group if you are unable to maintain the confidential and private nature of your location.
- You agree to participate in these remote group sessions, understanding that other clients will also be in locations that are not controlled by WMMHC.

==========

I agree to the three conditions stated above and will not have my child join a group session if I cannot reasonably expect to maintain the confidential and private nature of my child's location.

_____

Client's printed name

_____

Parent/Guardian's printed name

_____ _____

Parent/Guardian Signature Date

CSCT School Based Services
Welcome!

Thank you for allowing us the opportunity to work with you and your child. Your child will receive maximum benefit from our services if we are able to form an on-going, collaborative relationship with you as the parent/guardian. The following is a summary of what we will need from you to provide the best possible services to your child:

- CSCT provides services to youth and their families 12 months per year. This includes a summer program to ensure that skills learned and progress made during the school is not lost over the course of an extended break. The summer program allows for continued attention and focus on the therapeutic relationship, youth's progress and presenting issues and relevant family dynamics throughout the year.
- The CSCT program has a specific set of rules & regulations from the State of Montana. With these regulations comes the need to have paperwork reviewed and approved by the parent/guardian on a regular basis. Examples of these expectations are:

    - ✓ Quarterly review and update of the youth's individualized treatment plan with the parent's/guardian's signature.
    - ✓ Semi-annual review and re-authorization of releases of information documents.
    - ✓ Monthly participation in discussions regarding the progress your child is making on their individualized treatment plan.
    - ✓ Participation in annual Clinical Assessment updates to determine your child's eligibility for the CSCT Services.
    - ✓ Participation in family therapy is encouraged to promote consistency across the school/home/community settings.

- Information regarding changes in youth insurance coverage should be communicated to the CSCT Team as soon as you are aware of those changes to avoid out of pocket charges.
- Information regarding other service providers must be communicated to the CSCT Team, such as outpatient therapist, Case Managers, Youth Mentor, and/or Treatment Managers. This is to insure coordination of services and treatment plan focus. **Medicaid requires coordination between CSCT, Home Support Services and Outpatient Therapists**.
- I have read and understand the Expectations of Program Participation and agree to participate accordingly for the benefit of my child.

Parent/Legal Guardian: _____ Date: _____

WESTERN MONTANA
MENTAL HEALTH CENTER

AUTHORIZATION TO RELEASE INFORMATION

NAME:_____DOB:_____SSN: _____

Hereby authorizes_____to the following (initial all that apply)
via the following means:

_____RELEASE TO_____OBTAIN FROM _____Electronic_____Verbal_____Written

Name:_____**Relationship:**_____

Agency:_____

Address:_____

Phone:_____**FAX:**_____**e-mail**: _____

Specific Information to be RELEASED or OBTAINED (initial all that apply):

	Assessment		Medications		Peer Support Notes
	Treatment Plan		Discharge Summary		Nursing Notes
	Progress Notes		Crisis Evaluation		PACT notes
	Medical Notes		Group Home Notes		Crisis Facility Notes
	Consults		Day Treatment Notes		Safety Plan
	Presence in Treatment		Case Management Notes		Other

_____ I understand this could include information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Syndrome Virus), Psychiatric or Mental Health Care, Treatment for alcohol and/or drug abuse.

PURPOSE FOR DISCLOSURE:

_____I 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 after one year or as follows, whichever is sooner:

_____

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

_____To revoke this authorization, I must submit a written request to Western Montana Mental Health Center**.** I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____I understand that generally Western Montana Mental Health Center may not condition my treatment on whether I sign a consent form, but that I may be denied treatment if I do not sign a consent form for treatment or payment.

_____I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may no longer be protected by federal confidentiality rules.

_____I have received a copy of this authorization and the Privacy Rights Notice.

CLIENT SIGNATURE:_____ Date: _____

GUARDIAN SIGNATURE:_____ Date:_____

WITNESS SIGNATURE: _____

UPLOAD: ROI/PHI

WESTERN MONTANA
MENTAL HEALTH CENTER

AUTHORIZATION TO RELEASE INFORMATION

NAME:_____DOB:_____SSN: _____

Hereby authorizes_____to the following (initial all that apply)
via the following means:

_____RELEASE TO_____OBTAIN FROM _____Electronic_____Verbal_____Written

Name:_____**Relationship:**_____

Agency:_____

Address:_____

Phone:_____**FAX:**_____**e-mail**: _____

Specific Information to be RELEASED or OBTAINED (initial all that apply):

	Assessment		Medications		Peer Support Notes
	Treatment Plan		Discharge Summary		Nursing Notes
	Progress Notes		Crisis Evaluation		PACT notes
	Medical Notes		Group Home Notes		Crisis Facility Notes
	Consults		Day Treatment Notes		Safety Plan
	Presence in Treatment		Case Management Notes		Other

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_____I have received a copy of this authorization and the Privacy Rights Notice.

CLIENT SIGNATURE:_____ Date: _____

GUARDIAN SIGNATURE:_____ Date:_____

WITNESS SIGNATURE: _____

UPLOAD: ROI/PHI

CONSENT FOR TREATMENT

I consent to behavioral health treatment with WMMHC for myself/minor child/designee.

I understand all clients of WMMHC are eligible to receive a range of services addressing substance use disorders, mental health disorders, and medical issues (as applicable) on a limited basis.

The type and extent of services I/my child receive(s) will be determined through a collaborative treatment team effort and

through discussion with me/my child in the development of an individualized treatment plan.

I understand a range of behavioral health professionals, some of whom are in training, provide WMMHC services. Designated licensed staff provides oversight to all professionals in training.

I understand the various treatments offered provide significant benefits and may pose risks, which can be discussed with the treatment team. The process of behavioral health recovery may include relapse.

I understand some areas of WMMHC campuses are under camera surveillance to address safety and security concerns.

I understand the success of treatment is dependent upon motivation to change with the therapeutic support of WMMHC professional staff.

I understand if I am at least 16 years of age, I may consent to receive services from WMMHC without parental consent.

CLIENT RIGHTS

Effective Date April 2017

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving behavioral health services at any WMMHC facility.

2. You have the right to be treated without regard to physical or mental disability, unless such disability makes treatment afforded by the facility non-beneficial or hazardous. Treatment will reflect both your ability to benefit from services and others' treatment rights.

3. You have the right to practice your religion of choice, insofar as such practice does not infringe on the rights and treatment of others. You have the right to be excused from any religious practice.

4. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your behavioral health services. You have the right to a reasonable explanation, in terms you can understand, of your general condition; treatment objectives; the nature and significant possible adverse effects of recommended treatment; reasons this treatment is considered appropriate; and what, if any, alternative treatment services and types of behavioral health providers are appropriate and available.

5. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you, unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.

6. You have the right to confidential records. Although you must give written approval to allow your records to be released in most cases, there are some exceptions to this rule under state and federal law.

7. You have the right to request access to your records and the right to request corrections or amendments to your records. These and other privacy rights are explained more fully in WMMHC's Notice of Privacy Practices.

8. You have the right to the maximum amount of privacy consistent with the effective delivery of services to you.

9. You have the right to appropriate treatment and related services under conditions that are supportive of your personal liberty.

10. You have the right to not be subjected to experimental research or other experimentation without your informed, voluntary, and written consent.

11. You have a right to be free from abuse and neglect, or threats of abuse and neglect, while receiving services at WMMHC.

12. You have the right to a humane psychological and physical environment while receiving services at WMMHC.

13. You have the right to receive information about WMMHC's client grievance procedure and how to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate, available treatment. WMMHC recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect, WMMHC will provide a referral to a local client support group, a family member's support group, or a state designated advocacy agency.

14. You have the right to communication with family in emergency situations.

15. You have the right to receive services which reflect the awareness of the special needs of gender.

16. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and jail diversion programs and rights during an involuntary commitment process. A member of your treatment team will explain these rights to you if you have concerns.

GRIEVANCE PROCEDURE

WMMHC has established a grievance procedure for clients who believe their rights have been violated by the Center. If you feel your rights have been violated, please see any staff member to request a Grievance Form.

GENERAL AGGRESSIVE BEHAVIOR POLICY

All WMMHC Programs are designed to provide a safe place for our clients and staff. Aggressive behavior does not fit into this philosophy, and will not be tolerated at WMMHC facilities, against WMMHC staff, or other clients. Aggressive behavior is defined as yelling, pushing, physical fighting, throwing objects, swearing, or acting in a manner perceived to be threatening. If aggressive behavior occurs, WMMHC will follow the following established policies and procedures.

STEP ONE: You/your child will be asked to leave the program/office for the day and you/your child will be referred to a member of your treatment team to address the aggressive behavior.

STEP TWO: You/your child will be asked to leave the program/office for one week. Prior to returning, you/your child will be required to meet with a member of your treatment team to develop a plan for adherence to the policy.

STEP THREE: You/your child will be asked to leave the program/office for 30 days. Prior to returning, you will be required to attend a treatment team meeting to evaluate appropriateness for continued participation in the program.

The Executive Director and/or Program Manager may exercise discretion in following this procedure to protect the safety of clients, staff, and the program. At any time, if behavior is deemed as causing imminent danger to yourself or others, authorities may be called to intervene.

NOTE: Due to the unique nature of 24 hour crisis programs, residential programs, detention centers, and CSCT programs additional policies will apply.

SMOKING & WEAPONS

WMMHC is invested in the health and well-being of clients and staff. All WMMHC facilities are non-smoking which include all types of tobacco and e-cigarettes. No firearms or weapons are allowed at any WMMHC facility.

NOTICE OF PRIVACY PRACTICES
Effective Date April 2017

THIS *NOTICE* DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION, INCLUDING SUBSTANCE USE DISORDER TREATMENT RECORDS, MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT AND LEGAL DUTY

Western Montana Mental Health Center recognizes the importance of maintaining the confidentiality and security of your protected health information or 'PHI' (individually identifiable information relating to your past, present or future health condition, provision of health care to you, or payment for that health care). As required by law, we maintain safeguards to protect your health information against unauthorized access, use, or disclosure. We are required to give you this notice to inform you of our legal duties and your rights concerning your protected health information, and how we may use or disclose that information. WMMHC is required by law to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make the revised Notice effective for health information we already have about you and any we receive in the future. A copy of the current notice will be posted in a common area of our facilities. You may also request a copy of this notice at any time or access it on our website (www.wmmhc.org).

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

As a health care provider we use and sometimes disclose your PHI for the purposes of treatment (for example to coordinate your care with another provider), payment (verify eligibility and submit claims) and for health care operations (for example quality assurance and improvement activities). Except as outlined below, we will not use or disclose your protected health information for any other purpose or to any one else unless you have given us your authorization to do so. You may give us authorization to disclose your health information to anyone whom you designate. Your authorization must be in writing, using our Release of Information form designating what information may be released and to whom it may be released. You may revoke an authorization at any time but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect.

Your PHI related to **substance use disorder treatment** is protected by additional Federal laws and regulations which provide a higher level of protection in some circumstances. For example, under these laws, WMMHC may not say to a person outside WMMHC that you attend the program, nor may WMMHC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law. Other exceptions to permitted uses and disclosures of information related to substance use are indicated in the following section in this notice.

Uses or Disclosure of Your Protected Health Information Permitted or Required **Without** Your Authorization

When required by law. For example, we may disclose PHI when a law requires us to report certain information, or in response to a court order provided that certain regulatory requirements are met. We may also disclose PHI as required or permitted by law to report suspected abuse or neglect, and as required by authorities that monitor compliance with privacy laws.
In a medical emergency. We may disclose PHI to medical personnel in cases of medical emergency.
To avert threats to health or safety. In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement in certain situations such as when a threat is made to commit a crime on the program premises or against program personnel.
For research. We may disclose your information for scientific research if certain requirements are met.
Working with Business Associates. PHI may be disclosed to a qualified service organization or business associate who may perform various functions on our behalf or provide certain types of services such as WMMHC's legal counsel and our electronic health records system vendor. Agreements with such parties subject them to the same legal requirements regarding the protection of your PHI.
Relating to decedents. We may disclose certain information to coroners, medical examiners and/or funeral directors as consistent with the law.
Public Health / Health Oversight: We may disclose PHI as required to public health authorities and to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.
Treatment and Payment. We may use and disclose your PHI for treatment and payment purposes (described in the second paragraph of this notice). This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.
Military and Special Government Functions. If you are a member of the armed forces we may release information as required by military command authorities. We may also disclose information to Correctional Institutions or for national security purposes. This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.

Unless you object, we may also disclose your health information that is relevant to a family member, relative, close personal friend or any other person identified by you who is involved in your health care or payment related to your health care. This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.

Disclosures of Your Protected Health Information that **Require** Your Authorization

We will ask for your written authorization before we use or disclose your protected health information for any purpose other than those describe above. For example, we would require your authorization for the use or disclosure of psychotherapy notes in most cases (please note that progress notes are not considered psychotherapy notes). We would also require your authorization for uses or disclosures for certain types of marketing activities and any disclosure that constitutes a sale of health information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy. In most cases, you have the right to inspect and obtain a copy of your health information that we maintain in a designated record set. Usually, this includes health information that is used to make decisions about your care, as well as billing records, but does not include psychotherapy notes or information compiled for use in civil, criminal or administrative proceedings, or in other limited circumstances. You must submit your request in writing using our access request form, and we may charge a fee to cover the cost associated with providing you with a copy. In addition, we may deny your request to inspect and copy your information in certain limited circumstances. Depending on the circumstances of the denial, you may have the right to have this decision reviewed.

Right to Amend. If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend that information for as long as the information is kept by us. To request an amendment your request must be made in writing using our amendment request form. We may deny your request if, for example, we determine that your information is accurate and complete, or if the information was not created by us or is not part of the designated record set.

Right to Request Restrictions. You have the right to request a restriction or limitation on certain uses and disclosures of your health information. WMMHC is not required to agree to restrictions you request except under certain circumstances, but if it does agree, then it is bound by that agreement and may not use or disclose any information you have restricted, except as necessary in a medical emergency. Your request must be in writing and contain: the information you want to limit, whether you are requesting a limitation in the use or disclosure of your information, or both, and to whom you want the limitation applied.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information made by WMMHC. We are not required to provide an accounting of disclosures made to you, disclosures made pursuant to your authorization or certain other disclosures otherwise permitted or required by law (for example, disclosures made for the purposes of treatment, payment or healthcare operations). Your request must be submitted in writing and must specify a time period which may not exceed six years. The first list you request within a 12-month time period will be free; we may charge a fee for additional lists requested within the same 12-month period.

Right to Choose How We Contact You. You have the right to request that we communicate with you in a certain way or at a certain location. For example you may request that we contact you only by phone or mail or email and only at work or at home. We will accommodate any reasonable requests.

Right to a Paper Copy of this Notice. You also have the right to receive a paper copy of this notice at any time.

Right to be Notified of a Breach. You have the right to be notified if a breach occurs that may have compromised the privacy or security of your information.

QUESTIONS AND COMPLAINTS

You may contact WMMHC if you have a question about this Notice. You may also file a complaint with WMMHC or with the Department of Health and Human Services, Office of Civil Rights if you believe your privacy rights have been violated. You will not be penalized for filing a complaint. To ask a question or file a complaint with WMMHC submit your question or complaint in writing to:

Privacy Office, WMMHC
140 N. Russell St.
Missoula, MT 59801