Alliance Wellness Center

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Welcome to Alliance Wellness Center. We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. We are truly caring about our patients and want you to feel very comfortable with our entire staff. We recognize that each patient is an individual and our goal is to help our patients with their individual treatment needs. We strive to be thorough in everything we do, taking time to achieve the best that we can.

Enclosed you will find our new patient information packet. Please carefully read each page and fill out and sign the forms where indicated. Please note the entire package must be filled out and returned to us at least 24 hours before your first appointment. We will also need a copy of your driver's license or a photo I.D., your insurance card, and your medication prescription card at the time you deliver your new patient packet. If we do not have all of these items 24 hours prior to your first appointment, we are required to reschedule your appointment.

Appointments do not guarantee prescriptions. If you are currently on medications please be aware that you will need to continue with your current provider until you have become an established patient with Alliance Wellness Center. Medications are not guaranteed on your first visit. A provider at Alliance Wellness Center will discuss a treatment plan with you.

If you have any questions about the packet please call us at our Olympia office and we will be happy to answer your questions. We look forward to meeting you.

Please Print All Information

Date ______________________________

Referring Provider ______________________________ M.D.____ PA.____ A.R.N.P.____ Provider Phone: __________________

Primary Care Physician ____________________________ M.D. ____ PA. ___ A.R.N.P. ____ Provider Phone: __________________

Patients Name:____Male:__________Female: ________

Address: ____City_________________Zip__________________

Home Phone: _______________________Cell Phone: _________________________Message Phone: _____________________

Age: _____ Date of Birth: ____________ Social Security Number: ____________________Marital Status: ____________________

Name of Employer: ____ Work Number: ____________ Occupation: _______________

Spouse or Partner Name: ____________________________________ Name of Employer: _____________________________

Work Number: ______________________________ Occupation:____

In Case of Emergency, who should be notified?

Name: ____ Phone: _____________________Relationship:___________

Name: ____ Phone: _____________________Relationship:___________

Is Alliance Wellness Center allowed to leave appointment reminders, lab results or other health care information on your telephone answering/voicemail machine or cell phone? **Yes / No**

Parent Information if Patient is less than 18 years old

Parent Name: ______________________________Address:___________________________________ Home Phone:__________

Cell Phone: __________________Work Phone:_________________ Employer:____

Insurance Information

Primary Insurance Company Name: ______________________________

Name of Policy Holder: ______________________________ Relationship: __________

Date of birth of policy holder: __________ Social Security number of policy holder: __________

ID Number: __________ Group Number: __________ Policy Effective Date: ______

Secondary Insurance Company Name: ______________________________

Name of Policy Holder: ______________________________ Relationship to patient: ______

Date of birth of policy holder: __________ Social Security number of policy holder: __________

ID Number: __________ Group Number: __________ Policy Effective Date: ______

Prescription Medication Card Name: ______________________________

Name of Policy Holder: ______________________________ Relationship: __________

Date of birth of policy holder: __________ Social Security number of policy holder: __________

ID Number: __________ Rx Bin Number: __________ Group Number: ______ Effective Date: ______

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for serviced to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Name of Insured Signature: ____________________ Hereby Authorize (Name of Ins. Co) __________

PATIENT FINANCIAL RESPONSIBILITY

To pay and hereby assign directly to Alliance Wellness Center, all benefits, if any otherwise payable to me for their services as described on the attached form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Alliance Wellness Center, will be credited to my account in accordance with the above said assignment. I also understand that all past due accounts are subject to finance charges. We do provide a prior authorization service as a courtesy only; however, this can be incomplete. Ultimately you are responsible for insuring authorizations with your insurance. It will be up to you as the patient to call your insurance company and find out if our providers are "IN NETWORK" with your insurance. You will be responsible for any balance that may occur from our providers not being "IN NETWORK" with your insurance. If for any reason you should be sent to collections, we will charge you 40% of the amount owed, plus an additional $50.00.

I agree to pay for all services provided. I acknowledge and accept that it is my personal responsibility for payment in full for billed charges even where Alliance Wellness Center has been assigned partial benefits from government programs and insurance companies. I acknowledge failure to pay my financial obligations to Alliance Wellness Center may result in the referral of my account to a professional collection agency. I consent to Alliance Wellness Center to obtain a copy of my credit report or any other publicly available data related to my ability to pay. In the event of any dispute regarding payment, I agree to pay all collection costs or fees including but not limited to interest at the highest rate allowable under the law and attorneys' fees in the event legal action is taken.

PHONE AUTHORIZATIONS: You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you. and include in any such messages information required by law (including debt collection laws) and /or regarding amounts owed by you; (3) to send you text messages: (4) to use prerecorded/artificial voice messages and/or an automatic dialing device in connection with any communications made to you or related to your account.

I understand that this agreement extends to any affiliated service providers for such services provided that may bell separately from Alliance Wellness Center including. but not limited to: radiology, laboratory, pathology, or any other and accept my responsibility to pay these in accordance with the payment terms set forth by those providers. I understand that I have the right to ask about costs before services are provided to me and that costs are deemed liquidated once the provider has prepared and sent the first invoice to me.

Patient or Authorized Signature: ______________________________ Date: __________

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We are committed and required by law to preserve the privacy of your personal health information.. We are to provide you with Notice describing how medical information about you may be used and disclosed and how you can access this information

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for you r healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. These reasons being, you are an inmate in a correctional institution, we are so required or authorized by law.

As our patient, you have important rights relating to the inspection and copying of your medical information that we maintain, amending or correcting that information, obtaining an account of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our Notice from time to time. The effective date at the bottom right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice of your medical information, please contact the office manager at 360-339-5841.

Please list the family members or other persons whom we may inform about your medical condition and your diagnosis (including treatment, payment, and health care operations).

Name________________________ Relation________________________ Phone____________________

Name________________________ Relation________________________ Phone____________________

Please print the address of where you would like your billing statements and /or correspondence from our office to be sent if other than your home: ____.

All correspondence from our office will be sent in sealed, security envelope to the home address unless a different address is provided above.

Patient Name____ (Guardian if under 18 years old)

Patient/ Guardian Signature______________________________________ Date:______________

PAYMENT POLICY AND ELECTIONS

We accept Cash, Credit/Debit and Checks for payments.

Payments for services you receive in which you are billed for are to be paid within 30 days from the receipt of your statement. A finance fee of 12% will be added to any balance not paid within the 30 days.

Insurance:

1. We accept and bill most insurance plans. Extent of coverage may vary with each plan. Please contact your insurance company or employer regarding the extent and limitations of coverage. Any balance that may occur after the payment from insurance(s) will be the patient's responsibility. This will include any balances from immunoassay and urine drug screen testing.

2. Your insurance contract requires that the CO-PAYMENT be paid in full at time of service. A charge of $15.00 dollars administrative fee will be added if we have to bill you for your co-payment.

3. State law requires insurance companies to process any single claim within sixty (60) days. If payment has not been received in sixty (60) days, you will be responsible for the amount.

4. It is the responsibility of the patient to call their insurance company and confirm that their insurance is "IN NETWORK" with our providers. It will be the patient's responsibility to pay any balance that may occur because of our providers not being "IN NETWORK" with your insurance plan.

5. You are responsible for handling any delays or disputes involving your Insurance Company. Our office will provide any assistance when possible. We provide a prior authorization with insurances for appointments as a courtesy only. It is ultimately up to the patient and their responsibility to check with their insurance company to insure these prior authorizations have been done prior to your appointment. If they are not, the patient is responsible for the outstanding balance that may occur.

6. It is the patient responsibility to get referrals from their primary care physician when it is required by insurance.

Patient/Guardian Signature ____ Date_______________

Miscellaneous:

1. A $100.00 charge will be billed for a New Patient Appointment, cancelled without 24 hours' notice. Established patients will be charged $70.00. (This fee is not covered by any insurance carrier or State agency).

2. Patients may be discharged if they have 2 or more "no show" appointments.

3. All non-sufficient fund checks returned will have a $40.00 administrative fee added.

4. Alliance Wellness Center uses a certain laboratory for drug screen testing. Alliance Wellness Center declares, one of the providers has partial ownership in its laboratory of preference. Patients are free to choose any lab of their choice. Please contact your insurance company to be sure our lab of choice is in network with your insurance. Samples are taken at every appointment and randomly sent to the laboratory.

5. Patients could be called in for random pill counts and urine drug screen testing with any inconsistencies in urine drug screen results, aberrant behaviors, changes in medications etc. Patients will be responsible for any remaining balances.

I have read the above policy agreement and understand my responsibilities for payment of services rendered.

Patient/Guardian Signature____ Date_______________

MEDICAL HISTORY

Have you had any or currently had any of the following?

Hepatitis	Yes____	No_____	If yes, when?____________________
Skin Infections	Yes____	No_____	If yes, when?____________________
Pregnant	Yes____	No_____	If yes, how far along? ____________________
Asthma	Yes____	No_____	If yes, when? ____________________
Cancer	Yes____	No_____	If yes, when? ________ What type? ____________________
Lung Disease	Yes____	No_____	If yes, when? ____________________
Diabetes	Yes____	No_____	If yes, When? ____________________
Epilepsy (seizure)	Yes____	No_____	If yes, when? ____________________
Venereal Disease	Yes____	No _____	Type? ________________When?____________________
High Blood Pressure	Yes____	No_____	If yes, when? ____________________
HIV/AIDS	Yes____	No_____	If yes, when? ____________________
Heart Attack	Yes____	No_____	If yes, when? ____________________
Kidney Disease	Yes____	No_____	If yes, when? ____________________
Stroke	Yes____	No_____	If yes, when? ____________________
Endocarditis	Yes____	No_____	If yes, how long?____________________
Pancreatitis	Yes____	No_____	If yes, how long?____________________
MRSA infection	Yes____	No_____	If yes, how long?____________________

Have you had any nonfatal overdose hospitalizations? Yes/No If yes please explain. ____________________

____

____

Have you had any stool impactions requiring medical attention? Yes/No If yes please explain. ____________________

____

____

Other Medical problems, please explain____________________________________

____

____

Blood Transfusions Yes / No If yes/when?____________________

Allergies: ____

____

____

Surgeries:	Date:
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________

SOCIAL HISTORY

Tobacco: Yes / No If yes/packs per day ____ How many years?____ If stopped/ how many years?__________________

Alcohol Use: Yes / No If yes how often?________ How Much?__________ Last time you used alcohol?____________

Other habits: Yes / No If yes please explain:____________________________________

Marital Status: single / married / widowed / divorced/ partner How Long? ____________________

Children Yes / No If yes, how many?________________________Ages____________________________

CURRENT MEDICATIONS

Please PRINT ALL information

List all medications, strengths, and frequency currently taking: (over the counter & prescribed)

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Pharmacy Name: ____

Address:______________________________________Phone:_______________

FAMILY HISTORY

Do any health problems run in your family? Yes / No If yes, please list:______________________________

____

____

Are there any family members on chronic opioid therapy? Yes / No If yes, what medication: ____________

____

What type of childhood did you have? ____

____

____

Is there family with history of addiction? If yes please indicate substance(s) used: ____________________

____

____

Have family members been in recovery? If so was it beneficial? ______________________________

____

____

Did the family member(s) have medical problems associated with their use? ______________________

____

____

Is there a history of overdose related to family substances use? If so please explain: ________________

____

____

REVIEW OF SYSTEMS

Please check all that apply:

Constitutional: ( ) Weight loss/gain ( ) Fatigue ( ) Poor appetite ( ) Chills/Fever

Skin: ( ) Itching ( ) Hives ( ) Rash ( ) Non healing sores ( ) Skin abscess

Eyes/Ears/Nose/Throat/Mouth: ( ) Hearing loss ( ) Ringing ears ( ) Blurred vision ( ) Visual change ( ) Glaucoma ( ) Nose bleeds ( ) Chronic sinus problems ( ) Allergies ( ) Dry/Sore mouth

Respiratory: ( ) Recurrent cough ( ) Bronchitis ( ) COPD/Emphysema ( ) Shortness of breath

Cardiovascular: ( ) Chest pain ( ) Passing out ( ) Swelling of feet/hands ( ) Poor circulation

Endocrine: ( ) Weight gain ( ) Temperature intolerance ( ) Excess thirst ( ) Change in hair texture

Gastrointestinal: ( ) Nausea/Vomiting ( ) Constipation ( ) Heartburn ( ) Loss of bowl control

Genital/Urinary: ( ) Frequent urination ( ) Loss of control ( ) Burning ( ) Blood in stool/urine

Musculoskeletal: ( ) Muscle cramps ( ) Stiffness ( ) Swelling of joints ( ) Joint pain ( ) Muscle pain

Neurologic: ( ) Head injury ( ) Memory loss ( ) Paralysis ( ) Weakness ( ) Numbness

Blood/Lymphatic: ( ) Swollen glands ( ) Anemia ( ) Easy bruising

MENTAL HEALTH HISTORY

Please check the box of any conditions that apply now or in the past and a brief description:

Depression ( ) ______________________________

Anxiety ( ) ______________________________

Schizophrenia ( ) ______________________________

PTSD ( ) ______________________________

Suicide Attempt ( ) ______________________________

Other Conditions ( ) ______________________________

____

____

If you are currently being treated for any of the above, please provide your provider's name and number:

Provider Name: ______________________ Address: ______________________

Phone Number: ______________________ Fax Number: ______________________

HISTORY OF DRUG USE

Category of Drug. Circle or write in the drug(s) name.	Age of first Use?	Pattern of use over time?	Frequency of use in the past month?	Date and amount of most recent use?
Alcohol				
Caffeine				
Marijuana/Cannabis				
Uppers: Cocaine, Ritalin, Methamphetamine				
Downers: Anxiolytics/Sedatives/Hypnotics Benzos, Valium, Xanax, Rohypnol				
Painkillers: Heroin, Morphine, Oxycodone, Methadone				
Hallucinogens: LSD, PCP, Ecstasy				
Inhalants/Aerosols				
Steroids				
Nicotine: Cigarettes, Vapes, Crewing Tobacco				
Other:				
Other:				

HISTORY OF DRUG USE CONTINUED

Do you use to feel normal? ______ If yes explain? ____

____

Have you attempted to cut down on your use? __________ Explain: ______________________________

____

____

What made you successful when abstinent from drugs? ____

____

____

Have you ever had an overdose? ______ Date of overdose(s)? ________________ Where you treated in the ER? ______
What hospital(s)? ____

Do you have Narcan/Naloxone? ______ Have you ever had to use Narcan/Naloxone? ______ If yes explain? __________

____

____

Describe typical withdrawal symptoms. ____

____

____

Have you been in prior treatment for substance use disorder? ______ Date of treatment(s)? ______________________
What substance(s)? ____
What type of treatment program(s), name of facility, how long was each program and date(s)?

- Detoxification inpatient program: ____
- Inpatient program: ____
- Residential program: ____
- Outpatient program: ____
- Sober living environment: ____
- Opioid maintenance program: ____
- Chemical Dependence program: ____
- Twelve step program: ____
- Counseling: ____
- Support group: ____
- Complications: ____

What triggered the relapse? ____

____

What substance(s) were used when relapsing? _____________________________________
What pattern of use developed after relapse? ______________________________________

____

What was the longest period free of drugs in the past year? __________ Five years? ___________Lifetime? ___________

Do you live with anyone else who is or has used alcohol or drugs? _________ Does this person(s) need help? __________

Is your current living environment safe? ______ Supportive of your desire to be clean? ______ Explain? _____________

____

____

PATIENT HEALTH QUESTIONNAIRE - PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle a number.

0 = Not at all **1 = Several Days** **2 = More than half the days** **3 = Nearly Every Day**

1.	Little interest or pleasure in doing things	0 1 2 3
2.	Feeling down, depressed, or hopeless	0 1 2 3
3.	Trouble falling or staying asleep, or sleeping too much	0 1 2 3
4.	Feeling tired or having little energy	0 1 2 3
5.	poor appetite or overeating	0 1 2 3
6.	Feeling bad about yourself, or that you are a failure and have let you and your family down	0 1 2 3
7.	Trouble concentrating of things, such as reading or watching television	0 1 2 3
8.	Moving or speaking slowly that other people could have noticed	0 1 2 3
9.	Being so Fidgety or restless that you have been moving around a lot more than usual	0 1 2 3
10.	Thoughts that you would be better off dead, or of hurting yourself in some way	0 1 2 3

If you answered 1 - 3 on any of the above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please check one:

( ) Not difficult at all ( ) Somewhat difficult ( ) Very Difficult ( ) Extremely Difficult

Cage - Aid

1.	Have you ever felt that you ought to cut down on your drinking?	Yes / No
2.	Have you ever felt that you ought to cut down on your drug use?	Yes / No
3.	Have you ever felt bad or guilty about your drinking?	Yes / No
4.	Have you ever felt bad or guilty about your drug use?	Yes / No
5.	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	Yes / No
6.	Have you ever used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes / No

Opioid Risk Tool

Please check each box that applies

1. Family History of Substance Abuse ( ) Alcohol ( ) Illegal Drugs ( ) Prescription Drugs

2. Personal History of Substance Abuse ( ) Alcohol ( ) Illegal Drugs ( ) Prescription Drugs

3. Age (mark box if between 16-45) ( )

4. History of Preadolescent Sexual Abuse ( )

5. Psychological Disease ( ) Attention Deficit Disorder ( ) Obsessive Compulsive Disorder ( ) Bipolar
( ) Schizophrenia ( ) Depression

DAST-10 QUESTIONNAIRE

Please answer the questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section. These questions refer to the past 12 months.

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use?	No	Yes

GENERLIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by the following problems?

Not at all sure (0) Several days (1) Over half the days (2) Nearly every day (3)

1. Feeling nervous, anxious, or on edge.	0 1 2 3
2. Not being able to stop or control worrying.	0 1 2 3
3. Worrying too much about different things.	0 1 2 3
4. Trouble relaxing.	0 1 2 3
5. Being so restless that it's hard to sit still.	0 1 2 3
6. Becoming easily annoyed or irritable.	0 1 2 3
7. Feeling afraid as if something awful might happen.	0 1 2 3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________ Somewhat difficult _________ Very difficult _____________ Extremely difficult _________

READINESS TO CHANGE QUESTIONNAIRE

Strongly Disagree (-2) ☐ Disagree (-1) ☐ Unsure (0) ☐ Agree (1) ☐ Strongly Agree (2) ☐

	(-2)	(-1)	(0)	(1)	(2)
1. My drug use is okay as it is right now.	☐	☐	☐	☐	☐
2. I am trying to cut down on my use.	☐	☐	☐	☐	☐
3. I enjoy using but sometimes I use too much.	☐	☐	☐	☐	☐
4. I should cut down on my drug use.	☐	☐	☐	☐	☐
5. It's a waste of time thinking about my drug use.	☐	☐	☐	☐	☐
6. I have just recently changed my drug use habits.	☐	☐	☐	☐	☐
7. Anyone can talk about wanting to do something about their use, but I am actually doing something about it.	☐	☐	☐	☐	☐
8. I am at the stage where I should think about using less.	☐	☐	☐	☐	☐
9. My drug use is a problem.	☐	☐	☐	☐	☐
10. It's alright for me to keep using as I do now.	☐	☐	☐	☐	☐
11. I am actually changing my drug habits right now.	☐	☐	☐	☐	☐
12. My life would be the same, even if I used less.	☐	☐	☐	☐	☐

ALLIANCE WELLNESS CENTER

Authorization to Release Confidential Substance Use Disorder Pharmacy Information

Under Title 42, Part 2, Code of Federal Regulations

Patient name: ____

I authorize Alliance Wellness Center (AWC) to disclose or request any information needed:

Pharmacy Name: ______________________________________

______ To confirm the validity of my prescription(s) and for submission for payment for the prescription.

______ To the dispensing pharmacy to which I present my prescription or to which my prescription is called, sent or faxed, as well as to third party payers.

______ For assuring the pharmacy of the validity of the prescription, so it can be legally dispended and for payment purposes.

Print name: ____________________ Signature: ________________________

Date of Birth: ____________________ Date: ____________________

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate on (specific date, event or condition): ____

(If nothing is specified this consent will terminate in 365 days from date above.)

Termination of treatment

I understand that my part 2 protected records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time (verbally or in writing) to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows (specific date, event, or condition upon which consent expires).

Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

ALLIANCE WELLNESS CENTER: ABN FORM

Advanced Beneficiary Notice (ABN) Form for Commercial Insurances

Note: You need to make a choice about receiving these health care items and services.

WE ARE NOT REFUSING MEDICAL SERVICES. This notice is to inform you that your Insurance Company may not cover Medical Services you are requesting.

Description of Medical Services: Medication Assisted Treatment For Reason of: Substance Use Disorder

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully:

- Ask us to explain, if you do not understand why your Insurance Company probably will not pay.
- Ask us how much these items or services will cost you.

PLEASE CHOOSE ONE OPTION:

OPTION 1: YES

I want to receive these services because I have been notified by Alliance Wellness Center that in my case my Insurance Company may deny payments for the services Identified above. I understand that you may bill me for the services and that I may have to pay if my Insurance Company denies it. I have decided to have services identified above performed. If my Insurance Company denies payment I agree to pay the full amount.

Patient Signature: ______________________________ Date: ________________

OPTION 2: NO

I have decided not to receive these services since I am not willing to be personally responsible for the payment.

Patient Signature: ______________________________ Date: ________________

ALLIANCE WELLNESS CENTER

SUPPORT RESOURSES: MEDICATION ASSISTED TREATMENT (MAT)

Important Telephone Numbers and Resources

• If you have a life-threatening emergency: Call 911 or go to the nearest hospital emergency room. You don't need an authorization for crisis services.

• For 24-hour crisis support and referrals for substance use, problem gambling and mental health services, call the free and confidential Washington Recovery Help Line: 1-866-789-1511, TTY 1-206-461-3219 or visit them online at www.waRecoveryHelpLine.org

• To find crisis telephone numbers in your local service area visit: https:// www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/statemental-health-crisis-lines Washington State Division of Behavioral Health and Recovery for information about behavioral health services and who to contact (for all counties except Clark and Skamania) • Behavioral Health Benefits Book in multiple languages: https://www. dshs.wa.gov/bha/division-behavioral-health-and-recovery/behavioralhealth-benefits-book

• To find services in your area: www.doh.wa.gov/BHOcontacts

• To get more information about state-funded services: 1-360-725-3700, 1-800- 446-0259, or www.dshs.wa.gov/bha/division-behavioral-health-and-recovery Washington State Health Care Authority (HCA) For information about publically funded medical care, managed care plans, other mental health benefits, and transportation information: 1-800- 562-3022, TDD/ TTY only 1-800-848-5429, or 711 (for people with hearing or speech equipment). You can also send an email to: ASKMEDICAID@ hca.wa.gov or visit www.hca.wa.gov/medicaid. Washington State Aging and Long-Term Support Administration (ALTSA) For information about behavioral health services as part of long term care: 1-800-422-3263. Complaints/Ombuds: 1-800-562-6028. www.dshs.wa.gov/altsa Washington State Office of Administrative Hearings • 1-800-583-8271. www.oah.wa.gov. PO Box 42489, Olympia 98504 U.S. Office of Civil Rights • www.hhs.gov/ocr

BEHAVIORAL HEALTH RESOURCES

Great Rivers BHO Counties Served: Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum Telephone: 1-800-392-6298 Website: www.grbho.org

Crisis Lines:

- Cowlitz County Grays Harbor County 360-425-6064 1-800-685-6556
- Lewis County Pacific County 1-800-559-6696 1-800-884-2298
- Wahkiakum County 1-800-635-5989
- Ombuds: 1-855-851-1038

Greater Columbia BHO Counties Served: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima Telephone: 1-509-735-8681 or 1-800-795-9296 Website: www.gcbh.org

Crisis Lines:

- Asotin County Kittitas County 1-888-475-5665 1-800-572-8122 or 1-509-925-4168
- Benton County Klickitat County 1-800-783-0544 1-800-572-8122 or 1-509-773-5801
- Columbia County Walla Walla County 1-866-382-1164 1-509-524-2999
- Franklin County Whitman County 1-800-783-0544 1-866-871-6385
- Garfield County Yakima County 1-888-475-5665 1-800-572-8122 or 509-575-4200
- Ombuds: 1-509-783-7333 or 1-800-257-0660

King County BHO Counties Served: King Telephone: 1-800-790-8049 Website: www.kingcounty.gov/depts/community-human-services/mental-healthsubstance-abuse.aspx

Crisis Lines: 1-866-427-4747

- Ombuds: 1-206-477-0630 or 1-800-790-8049 (Press #3)

North Sound BHO Counties Served: Island, San Juan, Skagit, Snohomish, Whatcom Telephone: 1-360-416-7013 or 1-800-684-3555 Website: www.northsoundbho.org

Crisis Lines: 1-800-584-3578

- Ombuds: 1-888-336-6164 or 1-360-416-7004 (Ext. #1 or # 2) Optum

Pierce BHO Counties Served: Pierce Telephone: 1-253-292-4200 or 1-866-673-6256 Website: www.optumpiercebho.com

Crisis Lines: 1-800-576-7764

- Ombuds: 1-253-302-5311 or 1-800-531-0508 Updated 01-01-2018

Salish BHO Counties Served: Clallam, Jefferson, Kitsap Telephone: 1-360-337-7050 or 1-800-525-5637 Website: www.kitsapgov.com/hs/sbho/sbhomain.htm

Crisis Lines:

- Clallam County East County: West County: 1-360-452-4500 or 1-800-843-4793 1-800-843-4793
- Jefferson County East County: West County: 1-360-385-0321 or 1-877-410-4803 1-800-843-4793
- Kitsap County 1-360-479-3033 or 1-800-843-4793
- Ombuds: 1-360-692-1582 or 1-888-377-8174

Thurston/Mason BHO Counties Served: Mason, Thurston Telephone: 1-360-867-2602 or 1-800-658-4105 Website: http://tmbho.org

Crisis Lines:

- Mason County 1-800-270-0041 or 1-360-754-1338
- Thurston County 1-800-270-0041 or 1-360-754-1338
- Ombuds: 1-360-867-2556 or 1-800-658-4105

CHEMCIAL DEPENDENCY CENTERS

BHR Recovery Service 6128 Capital Blvd SE Olympia, WA 98501 360-704-7170

Providence St. Peter Chemical Dependency Center 4800 College St SE Lacey, WA 98503 360-456-7575

First Thing First 123 LLC 1905 4th Ave E B Olympia, WA 98506 360-338-0600

Eugenia Center 121 NW Chehalis Ave Chehalis, WA 98532 360-740-9767

Social Treatment Opportunity Programs 611 W Cota St Shelton, WA 98584 360-426-5654