❋

DIVERSUS HEALTH

What is included in the New Patient Paperwork?

❋ **Must be completed/signed and returned**

❋ **New Client Packet & History**: Please fill in your personal information to the best of your ability.

❋ **No Show, Late Cancellations, Discharge Policy**: We ask for at least a 48-hour advanced notice, but we know life happens. Please contact us as soon as you are aware you cannot keep your appointment time

❋ **Consent for Services/Treatment and Patient Acknowledgement**: Our Consent form is required in order to have the ability to see you. You're here because you want to be, and we will continue your care as long as is medically necessary.

❋ **Client Income Verification/Annual Re-Rate Form:** If you are ever in jeopardy of losing your insurance coverage, we still have an option to continue your care as a self-pay client. Please complete the financial information. If you know your coverage is expiring, please let us know as we will require some documentation in order to ensure you are charged the correct self-pay fee for service

Optional

Authorization for Disclosure of Protected Health Information Release: This form allows us to communicate with your Primary Care Physician and other care providers that you may be having services with. If there is an entity or individual, we should be working with while you are under our care, please complete the Authorization for Disclosure of Protected Health Information form.

Information for your records

Responsibilities and Rights: As a client of our organization, these are your rights. Please read and let us know if you have any questions.

Notice of Privacy Rights: Your care and the records we produce regarding that care, is protected by law. We will only speak to those individuals that you have authorized, and we will only share the information you have specified. If anyone else contacts us to ask about you, we will not provide any details regarding your care until you have authorized the individual.

Surprise/Balance Billing Disclosure Form: In accordance with Colorado State, please read the form and let us know if you have any questions.

Client Safety Rules: Requirements of our organization to ensure the safety of all we serve.

Emergency Response Procedures: Please read and let us know f you have questions or concerns.

Annual 2020 Poverty Guideline: Shows income levels and payments due, for clients that need to pay out of pocket for their appointments and services

Genoa Pharmacy and Quest Information: General information regarding hours and locations.

Service Animal Standards: Service animals are allowed at our locations, however if the animal is not under your control, we will ask that your animal be taken off our property.

Psychiatric Advance Directive: If there are special considerations or requests that we should consider as you are under our care, please complete the PAD form. We cannot guarantee that all your wishes will be honored but we will do our very best to follow

Please return completed paperwork marked with an ❋ to any of the following:

Drop off at our Lighthouse location: 115 S. Parkside Dr. Colorado Spring, CO 80910

Diversus Health New Patient, PO Box 15318, Colorado Springs, CO 80935

newpatient@DiversusHealth.org

Fax: 719-314-4257

✱
Date: _____

DIVERSUS HEALTH

New Client Packet

Demographics			
First name	MI	Last name	
Preferred Name	Date of Birth	Social Security Number	
Primary Language	Gender	Gender Identity	Sexual Orientation

Address			
Are you experiencing homelessness? ☐ Yes ☐ No			
Are you worried about losing your housing? ☐ Yes ☐ No ☐ I choose not to answer this question			
Physical	City	State	Zip
Mailing (If mailing address is the same as physical address check here ☐)	City	State	Zip
Home phone	Cell Phone	Other Phone	
Email address (please print)			

Emergency Contact		
First name	Last name	Relationship to you
Address	Home Phone	Cell Phone

Legal Guardian Information		
If Legal Guardian is also your Emergency Contact, check box ☐ *Proof of guardianship may be required Do you have legal guardian? ☐ Yes ☐ No (if yes, please complete contact information below)		
First name	Last name	Relationship to you
Address	Home Phone	Cell Phone

Primary Insurance		
Primary Insurance Are you the policy holder? ☐ Yes ☐ No	Insured ID	Group ID
If you are not the policy holder who is? First Name & Last Name		Relationship
Date of Birth	Social Security Number	Phone

Secondary Insurance		
Secondary Insurance Are you the policy holder? ☐ Yes ☐ No	Insured ID	Group ID
If you are not the policy holder who is? First Name & Last Name		Relationship
Date of Birth	Social Security Number	Phone

*

Primary Care Physician

Sharing information about how you access primary care helps us better understand how to support you across all areas of your healthcare needs. This information is confidential like all other records about your health and does not authorize us to contact your PCP or share any information with them, unless you provide written authorization to do so in the future.

Do you have a Primary Care Physician? ☐ Yes ☐ No

Are you willing to provide the primary care physician's name? ☐ Yes ☐ No (if yes, please complete below)

Organization	Physician/Doctor	
Address	Phone	Fax

Employment Status

☐ Full-time ☐ Homemaker ☐ Student/Job Training ☐ Disabled ☐ Volunteer ☐ Retired
☐ Part-time ☐ Unemployed ☐ Supported Employment ☐ Inmate ☐ Military

Education

Highest level of education: Currently Enrolled: ☐ Yes ☐ No

Military

Previous Military: ☐ Yes ☐ No Current Military: ☐ Yes ☐ No
If yes, which Branch:

Ethnicity

☐ Not Hispanic ☐ Yes, Hispanic (Mexican) ☐ Yes, Hispanic (Puerto Rican)
☐ Yes, Hispanic (Cuban) ☐ Yes, Hispanic (Other) ☐ Declined

Race

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African America
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Declined

Cultural/Spiritual Considerations

Please specify:

Place of Residence

☐ Assisted Living ☐ Group Home ☐ Independent Living ☐ Sober House ☐ Other

Living Arrangement

☐ Mother ☐ Spouse ☐ Sibling(s) ☐ Relative(s), Kin ☐ Foster Parent(s) ☐ Partner/Significant Other
☐ Father ☐ Alone ☐ Child(ren) ☐ Guardian ☐ Unrelated Person ☐ Other

Relationship Status

☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married ☐ Engaged

Support System (check all that apply)

☐ Spouse ☐ Parent(s) ☐ Child(ren) ☐ Family ☐ Friends ☐ Church ☐ Therapist

Do you feel safe at home?

☐ Yes ☐ No

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner in the past year
☐ I choose not to answer this question

How often do you see or talk to people that you care about and feel close to?

For example: talking to friends on the phone, visiting friend or family, going to church or club meetings

☐ Less than once a week ☐ 1 to 2 times a week ☐ 3 to 5 times a week
☐ More than 5 times a week ☐ I choose not to answer this question

Primary Source of Income

☐ Employment ☐ Disability ☐ Social Security, Pension, Retirement ☐ Other
☐ None ☐ Unknown ☐ Welfare, Public Assistance

Do you receive SSI or SSDI?

☐ No ☐ SSI ☐ SSDI

*

Household Information
How many family members, including yourself, do you currently live with? ☐ N/A *Only enter the number of family, do not include friends/co-workers/roommates.*
Are you the head of household? ☐ Yes ☐ No Your monthly income: Number of dependents in household: Total annual household income: Number of children:
In the past year, have you or any family member you live with been unable to get any of the following when it was really needed? Check all that apply ☐ Food ☐ Utilities ☐ Clothing ☐ Child Care ☐ Phone ☐ Other
☐ Medicine or any health care (medical, dental, mental health, vision) ☐ I choose not to answer this question
Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? Check all that apply
If you need assistance getting to your next Diversus Health appointment, please contact Envida at 719-633-4677. ☐ Yes, it has kept me from medical appointments or from getting my medications ☐ Yes, it has kept me from non-medical meetings, appointment, work or from getting things that I need ☐ Yes, it has kept me from both medical AND non-medical meetings ☐ No
☐ I choose not to answer this question
At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
☐ Yes ☐ No ☐ I choose not to answer this question

New Client History

Chief Complaint
Referral Reason: Evaluation and Treatment by Psychiatry Team for Medication
What brought you in?
What type of services are you looking for? (Check all that apply)
☐ Medication Management ☐ Therapy ☐ Substance Use
When did you symptoms start?
Have you previously suffered from this complaint? ☐Yes ☐No
Previous Treatment of this complaint?
Current Symptoms (Check all that apply)
☐ Anxiety ☐ Appetite Issues ☐ Avoidance ☐ Racing Thoughts ☐ Sleep Changes ☐ Depression ☐ Excessive Energy ☐ Fatigue ☐ Libido Changes ☐ Suspiciousness ☐ Hallucinations ☐ Impulsivity ☐ Irritability ☐ Risky Activity ☐ Crying Spells ☐ Loss of Interest ☐ Panic Attacks ☐ Guilt
Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer this question
Past Psychiatric History
Previous diagnosis/mental health ☐ Yes ☐ No If yes, previous diagnosis: If yes, previous care provided by:
Previous Inpatient Mental Health stays ☐ Yes ☐ No If yes, with who?
Previous Therapy ☐ Yes ☐ No If yes, with who?

*

History of Behaviors			
Self-Harm	**Suicidal Ideations**	**Suicidal Attempts**	**Homicidal Ideations**
History: ☐ Yes ☐ No	History: ☐ Yes ☐ No	History: ☐ Yes ☐ No	History: ☐ Yes ☐ No
Current: ☐ Yes ☐ No	Current: ☐ Yes ☐ No	Current: ☐ Yes ☐ No	Current: ☐ Yes ☐ No
Violence toward others	**Aggression toward others**	**Anger issues**	
Verbal: ☐ Yes ☐ No	Verbal: ☐ Yes ☐ No	Verbal: ☐ Yes ☐ No	
Physical: ☐ Yes ☐ No	Physical: ☐ Yes ☐ No	Physical: ☐ Yes ☐ No	
Family History			
Mental History	**Suicide Completion**	**Substance Abuse**	
Parent(s): ☐ Yes ☐ No	Parent(s): ☐ Yes ☐ No	Parent(s): ☐ Yes ☐ No	
Sibling(s): ☐ Yes ☐ No	Sibling(s): ☐ Yes ☐ No	Sibling(s): ☐ Yes ☐ No	
Child(ren): ☐ Yes ☐ No	Child(ren): ☐ Yes ☐ No	Child(ren): ☐ Yes ☐ No	
Substance History			
Previous Substance Use Treatment ☐ Yes ☐ No If yes, with who?			
Have you tried any of the following? (Check all that apply)			
☐ Marijuana ☐ Hallucinogens ☐ Heroin ☐ Tranquilizers ☐ Methamphetamines ☐ Ecstasy ☐ Benzos ☐ Cocaine ☐ Stimulants ☐ Pain Killers (Opiates)			
If you checked any of the above, list frequency and date of last use:			
Tobacco Use			
Currently use ☐ Yes ☐ No ☐ Inhalation ☐ Oral ☐ Both Amount used: History of use ☐ Yes ☐ No Age of first use: Year quit (if applicable):			
Alcohol Use			
Currently use ☐ Yes ☐ No Amount: Frequency: History of use ☐ Yes ☐ No Age of first use: Year quit (if applicable):			
Social History			
Are you a refugee ☐ Yes ☐ No			
Where did you grow up?			
Who raised you (relationship)?			
Siblings			
Brothers: ☐ Yes ☐ No Sisters: ☐ Yes ☐ No			
Family Relationships			
Stable Family Dynamics: ☐ Yes ☐ No Close Family: ☐ Yes ☐ No			
Trauma History			
Childhood ☐ Yes ☐ No Adulthood ☐ Yes ☐ No Witnessed Disaster ☐ Yes ☐ No Witnessed Traumatic Event ☐ Yes ☐ No			
Legal History			
Have you even been arrested? ☐ Yes ☐ No When?			
Reason?			
In the past year, have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correctional facility? ☐ Yes ☐ No ☐ I choose not to answer this question			

*

Medication - Current medication(s), include over the counter (use blank page if necessary)		
Medication	Dosage	Frequency
Allergies to medication(s), if yes, please specify below (use blank page if necessary) ☐ Yes ☐ No		
Medication	Reaction	Severity
Advanced Directive		
Do you have and Advanced Directive: ☐ Yes ☐ No		
Would you like information about Advanced Directives? ☐ Yes ☐ No		

Client or Parent/Guardian signature Date

Office Use Only

Provider reviewed all information with client during initial psychiatric evaluation.

Provider signature Date

Provider name

*

DIVERSUS HEALTH

CONSENT FOR SERVICES/TREATMENT AND PATIENT ACKNOWLEDGEMENT

1. **CONSENT FOR TREATMENT.** I voluntarily consent to behavioral health services and treatment performed by staff and providers at Diversus Health. This may also include treatment by a medical professional who can prescribe medication. I understand that the practice of behavioral health is not an exact science and no guarantees have been made to me as to the result of treatment. I understand that I have a right to consent to proposed treatment as well as a right to refuse proposed treatment. I also have a right to stop services and/or treatment at any time. I have a right to a second opinion regarding my diagnosis and my individual course of treatment.

2. **CONTACT.** I authorize Diversus Health to contact me regarding my services and/or treatment, appointment reminders, insurance items, or any call pertaining to my care. I authorize Diversus Health staff to contact me or my designated representative after discharge from services and/or treatment to obtain information for follow-up purposes only. I understand that these communications may occur in writing, secured email, phone, or text message. Should I choose not to receive text message reminders from Diversus Health, I will opt out of these services by contacting Diversus Health inwriting.

3. **TELEHEALTH SERVICES.** I authorize Diversus Health to use secured telehealth services, if necessary, to provide services and/or treatment. I understand that all laws that protect the privacy and confidentiality of medical information also apply to telehealth. I have the right to withdraw my consent to telehealth services at any time and it will not impact my right to care. Please note that therapy and medication management services cannot be rendered via telehealth if you are in another State unless the provider is credentialed in that State as well as Colorado. For providers credentialed in Colorado only, guidelines require that you be in Colorado to receive therapy and medication management services.

4. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I authorize Diversus Health to utilize confidential medical information or other information contained in my medical records as necessary for claims payments, medical management, or quality of care review purposes. I further authorize the release of such confidential information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management, and quality review activities as conducted by such company or plan or its subsidiaries or designees. This authorization includes the release of AIDS diagnosis or a positive HIV antibody result, alcohol and/or drug use/abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been provided to me.

5. **WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES.** I understand that Diversus Health does not assume any liability for the loss or damage to my personal property while on Diversus Health premises. I understand all valuables should not be brought or left at Diversus Health.

6. **PAYMENT AGREEMENT AND ASSIGNMENT.** Except as prohibited by an agreement between my insurance company and Diversus Health or by state or federal law, I agree to be responsible for my co-payments, deductibles, or other charges for services not covered or paid by insurance or other third-party payers. I authorize Diversus Health to file any claims for payment of any portion of the patient bills and assign all rights and benefits to Diversus Health, as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, and interest in the event that Diversus Health takes action to collect same because of my failure to pay in full any and all incurred charges.

7. **CANCELLATIONS.** I will give a minimum of 48 hours' notice for all appointments I need to cancel or reschedule. I understand that if I arrive late for a scheduled appointment I may not be seen and agree that unattended or late appointments may result in Diversus Health discontinuing services and/or treatment.

8. **Colorado Regional Health Information Organization (CORHIO)**. Clients who receive services at Diversus Health are automatically enrolled in CORHIO. CORHIO is the state-designated entity to lead efforts to expand the use of health information across Colorado. CORHIO facilitates the exchange of health information in the behavioral health community with the physical health care community to improve coordination of care so that important information about your healthcare is available to providers who render services for you. You do have the right to opt out of participation in CORHIO or revoke a previous opt out request you may have made.
   To OPT OUT of participation in CORHIO, please check box ☐

9. **ACKNOWLEDGEMENTS.** I acknowledge that I have been given/offered a copy of the following information;
   - **Client Rights andResponsibilities, Notice of Privacy Rights, including Confidentiality of Alcohol and Drug Abuse Patient Records, Advanced Directives, Client Safety rules (for in person services), Emergency Response Procedures (for in person services), Surprise/Balance Billing Disclosure, and this Client Consent forTreatment**

Staff Signature Date

Client Signature Date

☐ Check Box if Client/Legal Guardian refused/unable to sign (identify reason below):

*

No-Show, Late Cancellations, Discharge Policy

Diversus Health prides itself in the delivery of quality mental and behavioral health care and is in partnership with each client it serves. This partnership has two key components:

1. Providers dedicate each slot to one client at a time in order to provide top-notch care.
2. Clients show up for their appointments in order to receive proper care.

Diversus Health aims to provide compassionate, prompt, and reliable mental health care. We also aim improve the mental health of each client through the integration of psychotherapy, psychopharmacology, and mental wellness education.

By setting an appointment, we are reserving dedicated time for our clients to experience the benefits of care. We ask our clients to take pride in receiving these services by showing up and contributing in order to get the best possible outcome. We hold our providers responsible for showing up to clinics in a timely fashion and ask our clients to do the same.

Definitions:

Late Cancellation: Cancellation of an appointment less than 48 hours prior to the time of a scheduled appointment.

Late Arrival by client: Arrival of 15 minutes or later to a scheduled appt. (It will be up to the provider to determine if there is enough time remaining to be seen.

No-Show: Client fails to appear for a scheduled appointment without prior notification. (This type of cancellation is tracked to determine continued services with Diversus Health.)

Discharge: Clients can be administratively discharged from an individual service line (therapy, medical or group) and still receive other care at Diversus Health. Once administratively discharged from a service line, client will not be allowed to receive services for that specific service at Diversus Health.

Service Line Policies:

Initial/Psychiatric Diagnostic Evaluation: Clients who miss an Initial Diagnostic Evaluation, will not be granted another scheduled appointment. Instead, clients will be offered our Standby Lobby (virtual walk-in).

Therapy (includes Case Management and Skills Development)

- 3 missed therapy appointments in 3 months = Discharge from Therapy Services
- 6 therapy late cancellations in 3 months = Discharge from Therapy Services

Medication Management

- 3 missed medication management appointments in 3 months = Discharge from Medical Services
- 6 medication management late cancellations in 3 months = Discharge from Medical Services

Group Therapy

- 6 missed group appointments in 3 months = Discharge from Group Services per group type (i.e. DBT, SUD, ACT, etc.)

Crisis Center: Clients can always access crisis services if they have a crisis regardless of late cancellations or no-shows (*Medications will not be filled for clients via the crisis center*)

By signing this document, I understand the content of this policy and will comply by attending my scheduled appointments.

Client Signature Date

Print Client First and Last Name

*

Client Income Verification / Annual Re-Rate Form

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Patient Information		**Client ID:**	**Date**
First Name	Middle:	Last:	
Date of Birth:	SSN:	Other names:	
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Do you have insurance? ☐ Yes ☐ No	
Marital Status: ☐Single ☐In Relationship	☐Married	☐Divorced	☐Separated ☐Widowed

Household Size

Name	Relationship	DOB or Age

Household Income

	Name	Amount	Frequency (Circle one)	Employer
You		$	Weekly Monthly Yearly	
Spouse		$	Weekly Monthly Yearly	
Children		$	Weekly Monthly Yearly	
Other		$	Weekly Monthly Yearly	
			Weekly Monthly Yearly	
			Weekly Monthly Yearly	

Other Income

	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Child Support, Alimony					
Interest Income					
Other					
				Total	

Verification Type

☐ Paycheck stub (2 consecutive) – Most Current Year to Date (copy attached)
☐ Income Tax (Current Year): Year_____(copy attached)
☐ Letter of verification from Social Security (copy attached)
☐ Proof of Unemployment (copy attached)
☐ Self-Report (other income verification not available or self-employed – if self- employed report previous month's income)

I certify that the above information is true and accurate and that this report is made to assess my eligibility for State allocated funds for treatment expenses or to qualify me in Diversus Health's sliding fee scale.

My placement on the sliding fee scale is dependent on the federal poverty guidelines for the current year and my family size.

I understand that if any of the information or documents that I have provided proves to be NOT be accurate, Diversus Health may re-evaluate my financial status and take action necessary to collect any back payment that may be due for previously provided services on my account.

I understand that if my financial status changes or coverage for behavioral health services is obtained, I will notify Diversus Health immediately to re-evaluate my eligibility for the tiered fee scale.

I also understand that this tiered fee schedule is subject to change on an annual basis and may re-adjust my eligibility in my annual review.

Client or Legal Guardian Name (please print) Date

Client or Legal Guardian Signature

DIVERSUS HEALTH
PO Box 15318, Colorado Springs, CO 80935
Phone number 719-314-4283 and fax number 719-314-4257
Email: MedicalRecords@DiversusHealth.org

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name:_____ Client ID: _____

DOB:_____ Effective:_____

I do hereby consent and authorize Diversus Health to:

☐ Get information from and/or
☐ Release private (confidential) information to the following person(s) and/or entity.
Name: All my treating providers at_____

Address: _____

City:_____ State:_____ Zip: _____

Phone Number:_____ Fax Number: _____

Information To Be Released

The information that can be obtained/disclosed under this authorization includes the following:

- ☐ Assessments/Evaluations
- ☐ Person Centered Plans/Treatment Plans
- ☐ Progress Note
- ☐ Psychological Test/Reports
- ☐ Psychiatric Evaluations/Medication Reviews/Labs
- ☐ Treatment/Service Recommendations
- ☐ Other:
- ☐ Educational/Developmental
- ☐ Discharge/Transfer Recommendations
- ☐ Information Related to Benefits or Insurance
- ☐ Work Related Information

Transmission Modes

The information may be released in:

☐ Written ☐ Verbal ☐ Electronic ☐ Photo ☐ Other: _____

Purpose of the Release:

- ☐ To provide comprehensive case coordination
- ☐ To determine eligibility for services
- ☐ At the request of the individual
- ☐ Other:

DIVERSUS HEALTH
PO Box 15318, Colorado Springs, CO 80935
Phone number 719-314-4283 and fax number 719-314-4257
Email: MedicalRecords@DiversusHealth.org

Additional Information

Please note – The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

☐ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☐ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

I understand that:

-The requested information may not be protected from re-disclosures by the parties it is released to and is no longer protected under federal privacy laws; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulation (42 CFR part 2), the party this is disclosed to may not re-disclose such information without my further written authorization provided for by state or federal law.

- Substance Use Disorder related information can be released in the event of a bona-fide medical emergency without consent.
- Under 42 CFR Part 2, I have the right to request a list of disclosures to which disclosures have been made pursuant to the general designation
- For 42 CFR Part 2 violations, I can contact the US Attorney for Colorado at 1801 California Street, Suite 1600, Denver CO 80202, 1-303-454-0100
- Diversus Health has no control over this information after it is released and is not liable for any other disclosures.
- I may have a copy of this authorization.
- I may revoke this authorization at any time by notifying Diversus Health Medical Records in writing or by signing the revocation line of this form and returning it to Diversus Health Medical Records. Any revocation is for future releases and does not apply to any releases made prior to the revocation date.
- This authorization expires on_____or if left blank, two (2) years from my signature date.
- This authorization is not for the disclosure of psychotherapy notes, as Diversus Health does not maintain psychotherapy notes as part of the medical records.

Diversus Health Staff name: _____ Date: _____

Client signature (12 years of age and over) _____ Signature date _____

Client representative/Legal Guardian signature _____ Signature date _____

Client ID: Date:

Adult Substance Use Recovery Group Guidelines

1. **How to complete treatment:** Consistently attend group at the level you need based on the intake assessment. It is recommended that you continue in some aftercare program and/or other support group(s) for a year to ensure on-going recovery. You must attend the entire group session to receive credit toward completion.

2. **Missing groups:** Do not miss groups unless you absolutely have to do so. If you have to miss, make sure you tell your group facilitator as soon as possible prior to the group. If you miss a group and do not call, we will attempt to call you. Missing groups/no shows/late cancels may result in having to restart that level or having to meet individually with your therapist before returning to group.

3. **Drug and alcohol screening:** You will have the opportunity to participate in our UA program. These will be obtained on a random basis.
    a. **Positive Urinalysis**: If you are participating in the UA program, positive UA's may result in the need to increase level of care or may require the need to schedule a one-on-one session to discuss level of care and additional supports that may be needed.
    b. If you are participating in our MAT program and/or are required by probation, parole, DHS, etc. to submit UA's, you agree to be observed.

4. **Punctuality:** If you are more than 15 minutes late to group, expect to be turned away and asked to return next time the group meets.

5. **Cell phones/electronic devices:** When coming to group, leave all cell phones and electronic devices turned off or in your vehicle. Failure to do so will result in being asked to leave the group.

6. **Accountability:** The behaviors of others are not an excuse for you own behavior. You are in treatment with other people. They have different reasons of why they are in treatment. What may seem "unfair" to you may be appropriate for them because there are facts you don't know about other people in group. We will not tell you the circumstances of other clients due to confidentiality.

7. **Problems with other group members:** If you have an issue with someone that hinders your treatment experience, please discuss with program staff immediately for help in resolving the issue. Do not talk to others about it.

8. **Respect:** Respect each other. Do not have side-talk, bad mouth others, talk negative, name call, glamorize using inappropriate attire or swearing. Avoid them at all costs. Respect means that you will not come to treatment while intoxicated, under the influence of, or smelling of alcohol or any drugs. Doing so may trigger someone else.

9. **Relationships:** Although we encourage support from sober people, contact with other group members outside of group and/or the exchange of phone numbers will not be tolerated and will result in discharge from the program.

10. **Confidentiality:** It is very important to respect others confidentiality. Remember, what is said in group, stays in group. Disclosing any information about the group discussion or any of the group members will be reason for discharge from the program.

I have read this entire sheet and understand it. If I don't understand it at any time, I will contact a program therapist for clarification.

Client signature Date

COLORADO
Department of Corrections
Division of Adult Parole

Interstate Compact Unit
940 N Broadway
Denver, CO 80203
P 303.763.2408 F 303.861.1548
DOC_interstatetreatment.state.co.us

Revised January 2019

OUT-OF-STATE OFFENDER CLIENT QUESTIONNAIRE

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in a denial to attend the treatment program and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or DMV? ☐ Yes ☐ No

2) Do you have any pending cases, Probation/Parole supervision, or warrants in another state? ☐ Yes ☐ No

If yes to 1 or 2, please answer the following questions:

3) In what state was the crime committed? _____

4) Who are you to report the treatment to? _____
(Example: Court, Judge, Probation Parole, etc.)

5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado? ☐ Yes ☐ No

6) For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring you driving privileges as the result of an alcohol or drug related driving Offense in another state, but are not under court order to do so? ☐ Yes ☐ No

Your Name:_____ Date of Birth: _____

Social Security Number:_____ Place of Birth: _____

Signature:_____ Today's Date: _____

If you answered "Yes" to 1 or 2 above, please provide the following:

Name, address and phone number of your Probation officer, parole officer, judge Or diversion officer. _____

_____

_____

_____

A copy of your probation, parole, court or diversion order, including treatment requirements must be included.

Name: **Date:**

Infectious Disease Medical and Behavioral Screening

Please check the most accurate response to each question

1. Have you been a recipient of a blood transfusion or organ transplant (Including receiving blood during birth or other surgical procedures?

☐ Yes ☐ No

2. Have you ever been or are you now on long-term hemodialysis (when blood from an artery passes through a coiled membrane-tube and back into the vein?

☐ Yes ☐ No

3. Are you a recipient of clotting factor (a material that is given to help the blood clot when it cannot clot on its own)?

☐ Yes ☐ No

4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with Hepatitis C infected blood?

☐ Yes ☐ No

5. Did your birth mother have hepatitis?

☐ Yes ☐ No

6. Have you ever experienced (check all that apply):

☐ Yellow discoloration of the eyes and skin
☐ Nausea (unexplained for long periods of time)
☐ Loss of both appetite and weight
☐ Swelling of the abdomen
☐ Abnormal blood clotting (difficult to stop cuts/scratches from bleeding)
☐ Dilation of tiny arterioles (little arteries) in the skin – breast enlargement in men
☐ Abnormal liver function/enzyme test

7. Have any of your sexual partners been infected with Hepatitis B or C?

☐ Yes ☐ No

8. Have you ever received a body tattoo or body piercing?

☐ Yes ☐ No

9. Mark all of the following that apply to you (past or present)

☐ Close contact with active TB ☐ Treated for TB
☐ Have had an abnormal chest x-ray ☐ Have had a positive TB test

Have you ever been diagnosed with any of the following medical conditions?

☐ HIV ☐ Chlamydia ☐ Gonorrhea ☐ Cervical Cancer ☐ Kidney failure
☐ Diabetes ☐ Hepatitis ☐ Syphilis ☐ Genital herpes
☐ Bleeding/clotting disorders ☐ Any other immune disorder
☐ Specific malignancies (refers to a cancerous tumor that may spread throughout the body)

10. Have you ever spent time in Africa, Asia, Latin America, Eastern Europe or Russia?

☐ Yes ☐ No

11. Have you ever been employed as a health care worker or volunteer who served high-risk clients?

☐ Yes ☐ No

12. Have you been a resident or employee/volunteer at any of the following? (check all that apply)

☐ Correctional facility ☐ Nursing home ☐ Residential Treatment Facility
☐ Homeless shelter ☐ Mental institution ☐ Transitional Living facility

13. Mark all that apply to you (past or present)

☐ Have had a continuous cough for more than three weeks
☐ Have coughed up blood/colored mucous
☐ Swollen, non-tender lymph nodes (at the base of jaw or neck)
☐ Prolonged loss of appetite
☐ Unexplained weight loss of 10 pounds or more
☐ Recurrent fevers or heavy night sweats for more than three weeks

14. Have you had multiple sexual partners (more than one)?

☐ Yes ☐ No

15. Have you ever had anal sex?

☐ Yes ☐ No

16. How often have you used protection (condoms, etc.) when having sex?

☐ Never ☐ Sometimes ☐ Always

17. Have you used a needle to inject any substance in your body?

☐ Yes ☐ No

18. Do you know or suspect that your sexual partners ever injected any substance with a needle?

☐ Yes ☐ No

19. Have you or any of your sexual partners ever had? (Mark all that apply)

☐ HPV (Human Papilloma Virus) or genital warts
☐ Silicosis (a lung disease that is caused by inhaling silicon dioxide over a long period of time)
☐ Black lung or coal miner's disease (anthracosis: caused by coal dust in the lungs)

FOR OFFICE USE ONLY

Client Name _____ Client ID _____

Infectious Disease Questionnaire SCORING SHEET

Questions 1 through 7

- If there is a "Yes" response to any of the questions 1 through 7 and no record of being tested for Hepatitis B or C, make a referral for testing an appropriate follow-up.

Question 8

- If there is a "Yes" response to question 8, provide information about the possible (though low-level) risks of Hepatitis B or C involved in this activity.

Questions 9 through 12

- If there is a "Yes" response to any of the questions 9 through 12, recommend that the client get a TB test.

Question 13

- If there is a "Yes" response to any part of question 13, this indicates high risk for active TB or TB infection, HIV or Hepatitis. Make a referral to a healthcare practitioner or health department for testing/treatment.

Questions 14 through 19

Total the corresponding numeric values

14. Yes (5) No (0)
15. Yes (10) No (0)
16. Never (10) Sometimes (5) Always (0)
17. Yes (10) No (0)
18. Yes (5) No (0)
19. (5) for each item checked

Total Score: _____

Scoring Guide and Appropriate Clinical Responses

- Score 0 to 20 indicates low risk for acquiring/transmitting HIV. Brochure information on risk and treatment should be given to client.
- Score 25 to 40 indicates medium risk for acquiring/transmitting HIV and Hepatitis. Appropriate referrals should be provided pre- and post-counseling is needed
- Score 45 to 75 and higher indicates high risk for acquiring/transmitting HIV/hepatitis. The client should be referred to the appropriate agency for testing and pre- and post-counseling.
- A "Yes" response to question 17 indicates past or present injection drug use and testing for HIV, Hepatitis C and Tuberculosis should be strongly encouraged.

- All clients, regardless of score shall receive primary HIV and hepatitis prevention education in ADAD licensed treatment agencies.
- Only the Infectious Disease scoring sheet should be kept in the client record as documentation that the screening occurred.

Infectious Disease Questionnaire SCORING SHEET…continued

Staff Scoring Sheet Signature	Date
Client Name	Client ID
Name of Referrals given	Date of Appointment

I have accepted referrals for testing

Client signature	Date

Client refused referrals ☐

Responsibilities and Rights

Responsibilities

As a client of DIVERSUS HEALTH, you have the following responsibilities:

- To abide by the rules and regulations of DIVERSUS HEALTH, as they are made known to you.
- To be courteous and respect the rights and property of other clients, staff, and the facility.
- To participate in your service planning and in your treatment program.
- To arrive to your appointments on time or call if late or need to reschedule.
- To take medications agreed upon by you and your prescriber.
- To learn about your mental health benefits and how to use them.
- To protect your personal property.
- To update your address and phone information.
- To pay your bill, within your ability to do so.
- To familiarize yourself with your rights.
- To be a partner in your care including development of services and follow through on the treatment plan.
- To tell your therapist or doctor if you want to change your treatment plan or you do not understand or agree with the plan.
- Give your therapist or doctor the information he or she needs to give you good care

Rights

Individual Rights for all DIVERSUS HEALTH clients:

- The organization respects the rights of clients.
- The organization treats the client with respect, dignity and regard for their privacy.
- Clients are treated equally without discrimination based on race, religion, gender, age disability, health status or sexual orientation.
- Clients receive information about their rights.
- Clients receive information about your mental health benefits and how to use them.
- Clients receive medically necessary mental health care according to federal law.
- Clients are involved in decision about care, treatment, and services provided and receive services in accordance with the client agreement and service plan.
- Participate in social activities in accordance to the plan or care.
- Informed consent is obtained.
- Consent is obtained for recording or filming made for purposes other than the identification, diagnosis, or treatment of the clients.
- Clients receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services. Treatment options are presented in a way that is easy to understand.
- Clients can ask that a specific provider be included to the network.
- Clients have the right to refuse care, treatment, and services in accordance with the law and regulation.
- Clients have the right to a second opinion regarding diagnosis and treatment.
- Clients have the right to access, request amendment to, and receive an accounting of disclosures regarding his or her own clinical/service information as permitted under applicable law.
- Clients and, when appropriate, their families are informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.
- The organization respects the client's right to and need for effective communication.
- The organization addresses the resolution of complaints from clients and their families. Your client representative can be reached by calling 719-572-6100. This representative provides support/advocacy for any issues related to your treatment.
- The organization respects the needs of clients for confidentiality, privacy, and security.

Responsibilities and Rights

- Clients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation from their provider.
- Clients are free from sexual intimacy with a provider.
- Clients receive culturally appropriate/competent services including an interpreter if warranted.
- Clients are informed if there are changes in services, if their therapist stops seeing clients, or if DIVERSUS HEALTH stops providing a service you are receiving.
- Clients have the right to pain management.
- Clients have the right to access protective and independent advocacy services.
- Clients can tell others his or her opinion about DIVERSUS HEALTH including regulatory agencies, the government, or the media without it affecting how we provide covered services.
- The organization protects research subjects and respects their rights during research, investigation, and clinical trials involving human subjects.
- In organizations that provide opportunities for work, a defined policy addresses situation in which clients work for and on behalf of the organization. To be reimbursed at an appropriate rate for work performed on the premises for the benefit of the director, staff, or other clients, in accordance with the client's service plan.
- Clients receiving vocational rehabilitation receive information about the organization providing vocational rehabilitation services.
- Clients have a right to exercise citizenship privileges.
- Exercise choice in attending and participating in religious activities.
- Clients have a right to care with or without advance directives. Advanced directive information is available to clients and include applicable state law.
- Clients are free to use all of his or her rights without it affecting their treatment.
- Clients need to cooperate with the BHO when choosing or seeing a provider.

Acute Treatment Rights

- Clients are informed about DIVERSUS HEALTH's policies regarding the handling of medical emergencies.
- If a client is disoriented or in any state that impairs cognition at the time of entry, he or she is informed of his or her rights at an appropriate time during care, treatment, and services.
- Clients are informed of the program rules.
- Clients have the right to receive and send sealed correspondence. No incoming or outgoing correspondence shall be opened, delayed, held or censored by the personnel of the facility.
- Clients have the right to have access to letter writing materials, including postage, and to have staff members of the facility assist him/her if unable to write, prepare and mail correspondence.
- To have reasonable and frequent access to use the telephone, both to make and receive calls in privacy.
- Full use of the facility common areas, in compliance with the documented house rules.
- Expectation of cooperation of the facility in achieving the maximum degree of benefit from those services which are made available by the facility.
- To have frequent and convenient opportunities to meet with visitors. The facility may not deny visits by the client's attorney, religious representative or physician, at any reasonable time and to have privacy to maintain confidentiality of communication between a patient and spouse or significant other, family member(s), staff member(s), attorney, physician, certified public accountant and/or religious representative.
- To wear his/her own clothing, keep and use his/her own personal possessions within reason and keep and be allowed to spend a reasonable sum of his/her own money.
- To refuse to take psychiatric medications, unless the person is an imminent danger to self or others, or the court has ordered such medications.
- To not be fingerprinted unless required by law.
- To refuse to be photographed except for facility identification purposes.

Responsibilities and Rights

- For persons who are under certification for care and treatment, to receive twenty-four (24) hour notice before being transferred to another designated or placement facility unless an emergency exists, the right to protest any transfer to the court, and the right to have the transferring facility notify someone chosen by the client about the transfer.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To privacy and confidentiality of treatment records except as required by law.
- To accept treatment voluntarily, unless reasonable grounds exist to believe the person will not remain in treatment on this basis.
- To receive medical and psychiatric care and treatment in the least restrictive treatment setting possible, suited to meet the person's individual needs and subject to available resources.
- To request to see their medical records, to see the records at reasonable times, and if denied access, to be given the legal reasons upon which the request was denied and have documentation of such placed in the clinical record.
- To retain and consult with an attorney at any reasonable time.
- Every person who is eighteen (18) years of age or older shall be given the opportunity to exercise his/her right to vote in primary and general elections. The staff of the designated or placement facility shall assist each person in obtaining voter registration forms and applications for absentee or mail ballots, and in complying with any other prerequisite for voting.

Acute Treatment Rights Restrictions

- Except as otherwise provided, each denial of a person's right shall be made on a case by case basis and the reason for denying the right shall be documented in the clinical record and shall be made available, upon request, to the person or his/her attorney.
- No safety or security policy may limit a patient's ability to send or receive sealed correspondence. However, to prevent the introduction of contraband into the secure facility, the policy may provide that the patient opens the correspondence in the presence of unit staff.
- No safety or security policy may limit a patient's right to see his or her attorney, clergy, or physician. However, the safety and security policy may provide that advance notice be given to the secure facility for such visits so that the secure facility can adequately staff for the private visit.
- A person's rights may be limited or denied under court order by an imposition of legal disability or deprivation of a right.
- Information pertaining to the denial of any right shall be made available, upon request, to the person or his/her attorney.

Foster Care Only

- The child's rights are respected.
- The rights of the family of origin are respected.
- The foster family's rights are respected.
- Clients are given information about their responsibilities while receiving care, treatment, and services.

Mental health professionals are required to maintain records of the people they serve, 18 years of age and older, for a period of seven (7) years from the date of termination of services. Under Colorado law (C.R.S. 12-43-224), if you feel we have violated the law regarding maintenance of records for an individual 18 years of age and older, you must file your complaint or other notice with the Division of Professions and Occupations within seven
(7) years after you discover or reasonably should have discovered the violation. All records will be maintained as required under Colorado law. Please be advised that records for an individual 18 years of age and older may not be maintained after the seven-year period.

Colorado Department of Human Services (main information)	303-866-5700
Colorado Department of Human Services Office of Behavioral Health	303-866-7400
Colorado Legal Services	719-471-0380
District Attorney Neighborhood Justice Center	719-520-6016
Colorado Department of Human Services Office of Behavioral Health –Drug and Alcohol	303-866-7480

DIVERSUS HEALTH

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL [INCLUDING MENTAL HEALTH] INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, Diversus Health will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

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

A. General Uses and Disclosures Not Requiring the Client's Consent. The Center will use and disclose protected health information in the following ways.

1. *Treatment.* Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, Center staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

2. *Payment.* Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. For example, the Center will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payors may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicaid, information will be provided to the State of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

3. *Health Care Operations.* Health Care Operations refers to activities undertaken by the Center that are regular functions of management and administrative activities. For example, the Center may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

4. *Contacting the Client.* The Center may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. *Required by Law.* The Center will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating the client's death.

6. *Health Oversight Activities.* The Center will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.

7. *Crimes on the premises or observed by Center personnel.* Crimes that are observed by Center staff, that are directed toward staff, or occur on the Center's premises will be reported to law enforcement.

8. *Business Associates.* Some of the functions of the Center are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. *Research.* The Center may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed. 45 CFR § 164.512(i).

10. *Involuntary Clients.* Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

11. *Family Members.* Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

12. *Fund Raising.* The Center, or its institutionally related fund raising Foundation, may contact clients as a part of its fund raising activities. PHI will be used and disclosed for fundraising communications if Diversus Health contacts you to raise funds for the organization. However, you have a right to opt out of receiving such communications.

13. *Emergencies.* In life threatening emergencies Center staff will disclose information necessary to avoid serious harm or death.

14. *Colorado Regional Health Information Organization (CORHIO).* Clients who receive services at the Center are automatically enrolled in CORHIO. CORHIO is the state-designated entity to lead efforts to expand the use of health information across Colorado. CORHIO facilitates the exchange of health information in the behavioral health community with the physical health care community to improve coordination of care so that important information about your healthcare is available to providers who render services for you. You do have the right to opt out of participation in CORHIO or revoke a previous opt out request you may have made. You can do so by selecting the relevant check box in the Consents and Acknowledgements section of this document.

B. Client Release of Information or Authorization. The Center may not use or disclose protected health information in any other way without a signed release of information or authorization. When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the Center has already taken action in reliance thereon.
C. Uses and disclosures of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require authorization from you.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information the Center has regarding you, in the designated record set. You can obtain it in paper or electronically. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask Center staff for the

appropriate request form.

B. Amendment of Your Record. You have the right to request that the Center amend your protected health information. The Center is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask Center staff for the appropriate request form.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures the Center has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask Center staff for the appropriate request form.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. The Center does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask Center staff for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from the Center by alternative means or at alternative locations. For example, if you do not want the Center to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask Center staff for the appropriate request form.

F. Restricting Disclosures. You have a right to restrict certain disclosures of PHI to a health plan where you pay out of pocket in full for the health care service. Upon your request, Diversus Health must agree to a restriction on the disclosure of PHI to a health plan if: (1) the disclosure of PHI would be for the purposes of carrying out payment or health care operations, and is not otherwise required by law; and (2) the PHI pertains solely to a health care service for which you, or a person acting on your behalf, has paid Diversus Health in full.

G. Breaches. You have a right to be notified following a breach of unsecured PHI.

H. Psychotherapy Notes. If your provider keeps psychotherapy notes (informational notes about your care that is separate from the official clinical record), uses and disclosures of theses psychotherapy notes require authorization from you.

I. Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

III. ADDITIONAL INFORMATION

A. Privacy Laws. The Center is required by State and Federal law to maintain the privacy of protected health information. In addition, the Center is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice. The Center is required to abide by the terms of this Notice, or any amended Notice that may follow. The Center reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in the Center's service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe the Center has violated your privacy rights, you have the right to complain to Center management. To file your complaint, call the privacy officer at 572-6100. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 999 18^{the} Street, Suite 417, Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD), (303) 844-2025 FAX. It is the policy of the Center that there will be no retaliation for your filing of such complaints.

D. Additional Information. If you desire additional information about your privacy rights at the Center, please call 572-6100 and ask to speak to the privacy officer.

IV. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

A. The confidentiality of alcohol and drug abuse patient records maintained by this center is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

1. The patient consents 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.

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

C. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

D. Federal laws 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.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations).

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed: Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930- 3745.

***This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.**

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

DIVERSUS HEALTH

Client Safety Rules for Onsite Services

- Clients who are less than 12 years old must be checked in by the parent/guardian at each scheduled therapy appointment.

- It is required that a parent/guardian of a child/client who is less than 12 years old, remain in the building where services are being provided. Any exceptions (including remaining in the parking lot) must be approved in advance by the Diversus Health staff providing services at each scheduled appointment.

- The parent/guardian must attend all medical appointments.

- The parent/guardian of a client who is at least 12, but less than 15 years old may leave the premises where therapy services are being rendered only upon approval by the staff providing services, per scheduled appointment.

- Clients who are at least 12 years old may receive therapy services without a parent/guardian on the premises where services are being rendered. In some cases, the Diversus Health staff may elect to require the parent/guardian to be present while services are being rendered if clinically indicated.

- It is required that a child/client who is less than 12 years old, be under adult supervision by parent/guardian at all times on the Diversus Health campus. The parent/guardian must accompany the child/client while occupying restrooms, waiting areas, etc. Unless the child/client is under the direct supervision of Diversus Health staff.

DIVERSUS HEALTH

Emergency Response Procedures

- If you have questions regarding if Diversus Health is open due to weather or other significant circumstances, please call 719-637-8989 to determine if there are delayed openings or closures of facilities.

- If you or others are experiencing a medical emergency, 911 will be called to respond.

- If there are facility issues such as a fire, flooding, or other significant facility problems identified, please follow staff guidance on what actions to take particularly if asked to evacuate the building.

DIVERSUS HEALTH

Annual 2021 Poverty Guidelines

	Tier 5, $5 per day	Tier 15, $15 per day	Tier 25, $25 per day		Full Fee per Service	
Household / Family Size	At or Below 100%	125%	150%	175%	200%	Above 200%
1	$0-$12,880	$12,881-$16,100	$16,101-$19,320	$19,321-$22,540	$22,541-$25,760	$25,761+
2	$0-$17,420	$17,421-$21,775	$21,776-$26,130	$26,131-$30,485	$30,486-$34,840	$34,481+
3	$0-$21,960	$21,961-$27,450	$27,451-$32,490	$32,491-$38,430	$38,431-$43,920	$43,921+
4	$0-$26,500	$26,501-$33,125	$33.126-$39,750	$39,751-$46,375	$46,376-$53,000	$53,001+
5	$0-$31,040	$31,041-$38,800	$38,801-$46,560	$46,561-$54,320	$54,321-$62,080	$62,081+
6	$0-$35,580	$35,581-$44,475	$44,476-$53,370	$53,371-$62,265	$62,266-$71,160	$71,161+
7	$0-$40,120	$40,121-$50,150	$50,151-$60,180	$60,181-$70,210	$70,211-$80,240	$80,241+
8	$0-$44,660	$44,661-$55,825	$55,826-$66,990	$66,991-$78,155	$78,156-$89,320	$89,321+
9	$0-$49,200	$49,201-$61,500	$61,501-$73,800	$73,801-$86,100	$86,101-$98,400	$98,401+
10	$0-$53,740	$53,741-$67,175	$67,176-$80,610	$80,611-$94,045	$94,046-$107,480	$107,481+

For families/housholds with more than 8 person, add $4,540 for each Additional person.

Effective 1/28/21

aspe.hhs.gov

DIVERSUS HEALTH

genoa healthcare

Genoa pharmacy services located within Diversus Health

PLEASE NOTE: During COVID-19 quarantine, Genoa pharmacies are closed to the public. However, our Jet Wing and Moreno locations will mail medications.

Location	Type	Hours	Phone
1795 Jet Wing Dr.	Pharmacy	**Monday-Friday 8:30am-5:00pm** Closed 12:30pm-1:00pm	719-639-2256
875 W. Moreno Ave.	Pharmacy	**Monday-Friday 8:30am-5:00pm** Closed 12:15pm-12:45pm	719-630-3421
179 S. Parkside Dr.	CMC	**Monday-Friday 8:30am-5:00pm** Closed 12:30pm-1:00pm	719-572-6322

*CMC = Consumer Medication Coordinators who bring medications to site from pharmacy

Quest Diagnostics™

PLEASE NOTE: During COVID-19 quarantine,
patients are asked to visit the Quest location at
1380 E. Filmore St, Suite 110, Colorado Springs, CO 80907
Phone: 719-465-1593 / Fax: 719-465-1652

Monday-Friday 7am to 5pm, Saturday 8am to 12pm
Please call first as hours may have changed

****Appointments are Encouraged****
***client that are 60+ or at risk, can attend VIP hour (the first hour of the day)**

We welcome all ADA Approved Service Animals

To serve the needs of all our clients and guests, you may be asked by an employee if the animal is required because of a disability and/or what the animal has been trained to perform according to ADA compliance requirements.

The ADA **does not** recognize animals whose sole function is to provide comfort or emotional support.

www.ada.gov/service_animals_2010.pdf

Under Colorado state law HB16-1426 (effective January 2017), it is a crime to knowingly misrepresent an animal as a service animal. For example, indicating a non-service animal is a service animal to bring it into a public business that generally would not allow animals on the premises.

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices.

There are situations where we may ask that an ADA Service Animal be removed from the premises:

1) The animal is out of control and the handler does not take effective action to control it.

2) The animal is not housebroken.

DIVERSUS HEALTH

Please ask to speak to a supervisor if you have questions about Diversus Health's animal policy.

Psychiatric Advance Directive (PAD) FAQ

1. **What Is a Psychiatric Advanced Directive?** - *A psychiatric advanced directive is not* too *different from* a *medical advanced directive, which allows you to* express *your preferences insofar as your care goes. This can be particularly important if you become incapacitated* or *incompetent* for *any reason. While we cannot guarantee that such wishes will be followed, it can help* you *have greater control over your overall mental health care, especially in emergency situations.* For *instance, if there is* a *particular hospital you would want to utilize for inpatient mental health services, you can specify this within the advance directive.*

Z. **Can I write advance instructions regarding psychiatric medications and/or hospitalization?** - *Yes. If you want* to *specify instructions about medications or hospitalization, including refusals of either, they must take the form of instructions to your agent and include them on the Diversus Health PAD form; you should also thoroughly discuss your wishes with your agent.*

3. **Can** I **appoint an agent to make mental health decisions for me if** I **become incompetent? -** *Yes. This is accomplished by completing Part 3 of the Diversus Health PAD document.*

4. **Does anyone have to approve my advance instructions at the time** I **make them?** - *If you designate an agent under Part 3 of the Diversus Health PAD document, that individual will need to* agree *to and sign the PAD document in the designated location.*

5. **If** I **become incompetent, can my agent make decisions for me about medications, and/or hospitalization?** - *Yes, subject to the exceptions discussed under question 6 below. In general, if you are determined to be incompetent, your agent may make decisions about any health care issue that you could decide on if you were competent. However, you may* choose *to limit your agent's authority to* a *certain type, or types, of decision. If you wish to do this, you should document it clearly* on *the Diversus Health PAD form and discuss it thoroughly with your agent.*

6. **Does the statute say anything about when my mental health providers may decline to follow my PAD?**
   • *Yes. There are two important exceptions to the general rule that your providers must follow your agent's instructions. First, if you become subject to involuntary treatment or hospitalization under Colorado law, your providers are no longer required to follow your agent's instructions. Second, your provider must treat you in* a *"medically appropriate" way at all times. Therefore, if your agent's instructions were not considered "medically appropriate", your provider could decline to follow them.*

7. **Does my agent have to make decisions as he/she thinks** I **would make them (known as "substituted judgment"), or does he/she have to make them** in **my "best Interests"?** - *Your agent must exercise substituted judgment to the extent that he or she can do* so, *based on your advance instructions and/or on your preferences* as *known by the agent. If it* is *not possible to make* a *decision in that way, your agent must make the decision in your best interests.*

8. **Is there any rule that says that** I **can only make advanced instructions, only appoint an agent, or that** I must do both? - Yes. *As described above, the Colorado statutes do not allow consumers to make instructions alone, with the important exception of decisions about life sustaining treatment. Mental health consumers must appoint an agent in order to engage in advance decision making.*

9. **Before following my PAO, would my mental health care providers need a court to determine** I **am not competent to make a certain decision?** - *No. The statute does not specify how incompetence* is *to be assessed; in practice, your agent's authority would normally begin at the point your treating provider determines that you* are *not able to* make *your own mental health care decisions. If you wish your* agent's *authority to begin at* a *different point, you may specify that on Diversus Health PAD document.*

10. **How** Jong **does my PAD remain valid?** - *Your Diversus Health PAD* is *valid for 2 years from when signed if you do not revoke it before that time. You may revoke it at any time; your agent may also decide to cease acting for you at any time. Your Power of Attorney automatically becomes invalid in the event of a legal separation or divorce if your* spouse is *named* as *your agent.*