**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**(Intensive Care- Adolescent ASAM Level III.5)**



**ADMISSION PACKET**

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**(Intensive Care- Adolescent ASAM Level III.5)**

**1111 Coburn Road**

**Billings, MT 59101**

**Referral Information**

Participant’s Legal Name Date of Possible Admission \_\_\_\_\_\_\_\_\_\_\_

S.S.N. Gender: M\_\_\_\_\_ F\_\_\_\_\_ Date of Birth

Current Residence Address

City State Zip Phone

Last School Attended Address

City State Zip Phone

Legal Guardian/Custodian Relationship to Participant

Please circle one: Temporary Permanent Joint

Guardian Address City State Zip

(If guardianship is other than parent, provide court documentation.)

Tribal Counselor Agency

Address City State Phone

Current Medications (if any):

Prescribing Psychiatrist Phone

Allergies: Allergies Action Plan:

Name of Person Completing this Form Phone

Also, please include the following information for admission packet completion:

Participant’s court status (if applicable).

Copy of participant’s birth certificate, Medicaid card, Insurance card, Prescription/Pharmacy card.

Documentation of current custody/legal guardianship of participant.

Cumulative health records and medical history including immunization records & prescription eyewear.

Most recent psychiatric evaluation, biopsychosocial assessment, chemical dependency assessment & other pertinent clinical reports.

Educational records.

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**(Intensive Care- Adolescent ASAM Level III.5)**

**Participant Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Placement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Birthplace

Gender Religious Preference

Tribe Enrollment #

Complexion Weight

Legal Guardian of Youth

Address Phone #

Social Security #

Payment Source (Indian Health Service, Board of Tribal Health, Tribal Drug Court)

Other Source

Name of Last School Attended Grade

Father’s Name Mother’s Name

Address Address

Home Phone Home Phone

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**(Intensive Care- Adolescent ASAM Level III.5)**

**Participant Information Sheet Continued**

Placement Agency/ Referral Source: (Tribal Alcohol Program, Tribal/ BIA Social Services, Tribal Drug Court, HIS Behavioral Health)

Address

Referral Source Contract Person Name

Phone

Significant Others

Address

Phone

Additional Information (Contact Restrictions, etc.)

Completed by Date

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Contact Sheet**

Resident Date of Arrival

Placing Agency Case Manager

Probation Officer

Resident may have passes with the following:

Name Relationship Address Phone

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident may have phone contact with the following:

Name Relationship Address Phone

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Anyone who is not on the list will not be allowed contact with the resident.

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Placement Agreement**

(guardian)

Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Youth who are referred to New Day, Inc., for possible placement are those having difficulty in their home, school and/or community. Any youth who is referred will be considered for placement at New Day, Inc. The goal of New Day, Inc. is to offer youth a program of service and care to meet their individual needs. If a youth is accepted, efforts will be made to help the youth learn social, academic, self-maintenance and similar skills to aid the youth in a better adjustment with family, teachers, peers, and members of the community. Efforts are made to return the youth to a community placement as soon as possible. Exact plans depend on the youth’s needs and family situation.

With this understanding, I have decided that the problems of my child are serious enough to warrant placement of my child at New Day, Inc. I understand my child will be considered for residence in the New Day, Inc., home environment program. I agree to the terms contained in this Placement Agreement as set forth herein.

I understand that at the discretion of New Day, Inc., in accordance with the treatment plan, my child will be able to spend holidays and vacation time with me if applicable. I agree that I am responsible for my child during such periods and will notify the staff of New Day, Inc., immediately if any evidence of difficulty should appear. For example, if my child runs away or becomes physically abusive or is arrested, I agree to contact New Day, Inc. immediately to inform it of such happenings. I also agree to return my child “on time” in accordance with plans made with New Day, Inc.

I give my permission to New Day, Inc. to use physical restraints in the event that it is necessary for safety and to protect the health of my child, New Day, Inc. staff, visitors and others. It is understood that physical restraint in this context means holding the arms of my child to prevent injury to my child or other people. I understand that New Day, Inc. does not have legal authorization to restrain residents from leaving. Should my child leave the New Day, Inc. property unauthorized, I hold New Day, Inc. harmless of legal responsibility for any accident, injury, or crime incurred by my child or as a result of my child’s actions off of New Day, Inc. property.

I further give my permission to New Day, Inc. to notify the Yellowstone County Sheriff’s Department, the appropriate tribal law enforcement agencies, the referral agencies, and myself, if my child should leave or run away.

I understand that the New Day, Inc. program includes physical activities such as basketball, volleyball, horseback riding and similar vigorous activities. I understand that my child will be given proper instruction in both the use of equipment and safety procedures associated with any physical activity and will not be allowed to participate in the program until he/she has demonstrated competency in the activity. I further understand that I must give separate written authorization prior to my child being able to participate in the New Day, Inc. Riding Program and Sweat Lodge Activity. I understand that my child will be under staff supervision at all times while he/she is given proper instruction, as well as when participating in the physical activities. Unless my child has some physical limitations that make it medically unwise to participate if he/she so desires, I authorize such participation. I also will allow him/her to travel with teams and similar groups for such participation.

I understand that New Day, Inc. has a farm/ranch work program. I understand that while my child is at New Day, Inc. he/she may at one time or another operate equipment such as lawn mowers, weed eaters, or other yard tools as well as be involved in occasional cleaning of horse stalls and corrals and feeding horses as part of his/her

independent living skills, which is part of the New Day, Inc. program. I understand that my child will be given proper instruction in both the use of equipment and safety procedures associated with their use and that he/she will not be allowed to operate such equipment until he/she has demonstrated competency in the operation of such equipment and machinery. I understand that while being given the proper instruction and safety training procedures, my child will remain under constant staff supervision when operating equipment and tools and while working around the horse corrals and areas.

I understand that, given the difficulties my child is experiencing, placement at New Day, Inc. is the most appropriate and least restrictive placement.

Finally, I agree that if for any reason New Day, Inc. determines it is necessary to discharge my child from its care, I agree to accept my child back into my home and assume all responsibility for his or her care. I further agree to any arrangements made by New Day, Inc. to transfer my child back into my care, and to pay New Day, Inc., for all costs it incurs to transport my child back into my care.

Participant Name

\*\*Parent/Guardian Signature Date

New Day, Inc. Staff Signature Date

(Youth signature obtained on Placement Agreement in Youth Handbook *(electronic file- Section 2- Handbook)).*

**New Day, Inc**

**PROGRAM RELEASES**

Name of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HORSE PROGRAM**

I give permission for my child to participate in the New Day, Inc. Horse Riding Program. I understand that my child will participate in a therapeutic riding program that is goal oriented to reach youth potential through the use of horsemanship. Youth will attend and satisfactorily complete 4 hours of orientation training on horsemanship, before being allowed to ride the horses. The orientation will include the proper use of safety equipment and knowledge of the appropriate basic safety skills necessary. An experienced horse person will facilitate the presentation.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SWEAT LODGE ACTIVITY**

I give permission for my child to participate in the New Day, Inc. Home Sweat Lodge Activity. I understand that my child will participate in an outdoor adventure activity that is therapeutically designed to reach the youth’s spiritual, mental, and physical potential through the use of the sweat lodge ceremony. Due to the possibility of excessive sweating causing adverse interaction with medications they might be taking, I understand that my youth’s participation in the sweat lodge activity must be approved by a physician. I further understand that if my youth has a known heart disease, or is taking Benzodiazepines (Xanaxa, Valium) they will not be allowed to participate in the sweat lodge activity. An experienced seat lodge leader will facilitate the activity.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDIA RELEASE**

I authorize New Day, Inc to use photographs, digital images, or videotapes of my child for, among other things, public relations, school activities, advertisements, website, and fundraising activities. I further understand that I may deny use of my child’s image and name in some or all of these activities by submitting a written withdrawal of permission to: New Day, Inc., P.O. Box 30282 Billings, MT 59107. The withdrawal of permission must be received within 30 calendar days of admission.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECREATION ACTIVITIES RELEASE**

I give permission for my child to participate in recreational activities at New Day, Inc. The activities are designed therapeutically to challenge youth physically and mentally. Recreation activities will also teach youth life skills and how to work as a team. I understand that if my child is not capable of certain activities that he/she will not be forced to participate. An experienced recreation staff will facilitate the activities and requirements.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Authorization for Release of Student Records**

Name of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All public schools attended \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone) (Fax) (Phone) (Fax)

Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Student)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Birth Date) (Grade)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the parent/guardian of the above named student, hereby authorize the release of any and all of his/her educational records.

I acknowledge notification of this transfer of records as required by the Family Education Rights and Privacy Act of 1974. I understand that the student and/or I have a right to receive a copy at our own expense, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and interpreted as necessary by competent school personnel. They will not be transmitted to a third party without my consent.

Parent /Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Authorization for Disclosure of Confidential Health Care Information**

The undersigned hereby authorizes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose certain confidential health care information concerning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant) to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You are authorized to disclose all documents and files in your possession, including, but not limited to, admitting reports, discharge reports, summaries, progress reports, office records, hospital records, diagnostic test results, billing records, notes, correspondence, or any other documents relating to the treatment or evaluation of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant).

This Authorization shall be valid for thirty (30) months from the date recorded on this Authorization unless otherwise specified or revoked. The undersigned understands that this Authorization may be revoked at any time, upon written notification to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, except to the extent that action has been taken in reliance thereon.

The undersigned understands that this Authorization may include disclose of ALCOHOL AND DRUG ABUSE records which are protected by virtue of the provisions of Federal Regulations (42 C.F.R. Part 2)

The undersigned makes this Authorization upon the promise that all disclosures of any alcohol and drug abuse records made pursuant to this Authorization shall be accompanied by the following notice:

NOTE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of the information is NOT sufficient for this purpose.

The undersigned hereby acknowledges that he/she read, is familiar with, and fully understands the terms and conditions of this Authorization.

Photocopies of this signed Authorization shall be treated as executed originals.

Print Participant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of this document is to be delivered to the participant.

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**(Intensive Care- Adolescent ASAM Level III.5)**

**Authorization to Use and Disclose Health Information**

Name: Date of Birth:

Maiden or Other Name:

To:

Print Name Print Address

My health information may be disclosed under this authorization as marked:

* I authorize disclosure of the following types of individually identifiable health information maintained by you to New Day, Inc. Four Dances Residential Program.
* I authorize New Day, Inc. Four Dances Residential Program to disclose to you the following types of individually-identifiable health information.

Health information that may be used and disclosed through this authorization is as follows:

\_\_\_\_\_\_\_\_\_\_ Intake History/ Admission Information \_\_\_\_\_\_\_\_\_\_ Medication Records

\_\_\_\_\_\_\_\_\_\_ Psychological Testing \_\_\_\_\_\_\_\_\_\_ Psych/ Social Information

\_\_\_\_\_\_\_\_\_\_ Progress Notes/ Report \_\_\_\_\_\_\_\_\_\_ Treatment Plans

\_\_\_\_\_\_\_\_\_\_ Chemical Dependency Assessment Summary \_\_\_\_\_\_\_\_\_\_ Discharge Summary

\_\_\_\_\_\_\_\_\_\_ ACT Evaluation/ Recommendation Report

\_\_\_\_\_\_\_\_\_\_ Other (provide specific description of the information):

Specific purpose for the use or disclosure:

1. I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment.
2. I understand that information released by me may be subject to re-disclosure, and the information may no longer be protected by federal laws governing privacy of health information. However, if this disclosure consists of information about a client involved in chemical dependency services the following applies:

PROHIBITION OF REDISCLOSURE: 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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A federal authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. I understand that I may revoke this authorization in writing at any time. I understand that I must submit a written notice of revocation to the Administrator of New Day, Inc. I understand that the revocation will not apply to information that has been released in response to this authorization prior to my written notice.
2. I understand that my records may be transmitted by fax.
3. This consent will expire one hundred days (100) from the date this authorization is signed.
4. I have received a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Witness Signature Date

Parent or Personal Representative Signature Date

Description of Personal Representative’s authority to act for the client:

New Day, Inc. Four Dances Residential Program Staff accepting authorization:

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Your Rights Regarding Your Health Information**

1. Communications: You can request that our facility communicate with your about participants health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of our health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of the participant’s health information to only certain individuals involved in the participant’s care or the payment of the participant’s care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat the participant.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about the participant, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to New Day, Inc.
4. You may ask us to amend the participant’s health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to New Day, Inc. You must provide us with a reason that supports your request for amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, please contact New Day, Inc.
6. Right to file a complaint. If you believe the privacy rights of the participant have been violated, you may file a complaint with our facility or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact New Day, Inc. All complaints must be submitted in writing. The participant will not be penalized for you filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our facility will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or out health information privacy policies, please contact New Day, Inc.

I hereby acknowledge that I have been presented with a copy of New Day, Inc. Notice of Privacy Practices.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Notice of Privacy**

Name of Participant:

This notice describes how health information about the participant may be used and disclosed, and how the participant can get access to the participant’s health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to the participant’s privacy:**

Our facility is dedicated to maintaining the privacy the participant’s health information. We are required by law to maintain the confidentiality of the participant’s health information:

**Use and disclosure of the participant’s health information in certain special circumstances:**

The following circumstances may require us to use or disclose the participant’s health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to the participants health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If the participant is a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if the participant is an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Parent/ Guardian Signature

Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**(Intensive Care- Adolescent ASAM Level III.5)**

**Authorization for Treatment & Examinations**

The undersigned hereby authorize New Day, Inc. Four Dances Residential Program, Billings, MT (hereinafter referred to as Four Dances) to provide an enrollment biopsychosocial assessment, mental health assessment, psychiatric assessment (if deemed necessary) and routine medical care and treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) as the Four Dances staff consider to be necessary and as established pursuant to an existing treatment plan. We/I also give consent for continued testing as appropriate and pertinent for my child which may include psychological, academic, and/or physical testing.

The nature, purpose, and benefits of these routine treatments, the possible alternate methods to these treatments, any risks involved, and any possible side effects or complications arising from them will be explained to the undersigned and the patient prior to their use. Non-routine care and treatment or medications will not be administered to the patient without the undersigned and/or patient’s informed consent.

The undersigned hereby consent to the rendering of such emergency medical treatment as may be necessary in the event of a medical emergency either while on an expedition, while completing a challenge activity or while at Four Dances facility. The Four Dances staff will make every reasonable effort to notify the undersigned in advance of such treatment, unless doing so creates a life-threatening situation. Should more comprehensible emergency medical treatment be necessary, the undersigned consent to the transfer of the patient to a local general hospital facility for medical treatment.

(Participant Name) (Parent/Guardian) (Agency Representative)

(Date) (Date) (Date)

(Address) (Address) (Address)

(City, State, Zip) (City, State, Zip) (City, State, Zip)

(Witness)

**New Day, Inc.**

**Four Dances Residential Co-Occurring Treatment**

**Medication Authorization Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name of program)

to dispense to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following medications, as prescribed by

(name of participant)

a State licensed psychiatrist:

Specific purpose for the medication use:

Potential benefits for the medication:

Potential risks for the medication:

Potential alternatives for the medication:

This form addresses medications at time of participant’s admission, in addition to any medication changes/additions/deletions that are made by a licensed physician during participant’s stay at Four Dances. I understand and have been informed of the potential benefits, risks, and alternatives for the current prescribed medication. I will be notified by phone, writing, or in person of any medication changes/additions/deletions that are made by a licensed physician during participant’s stay at Four Dances in addition to the potential benefits, risks, and alternatives for the prescribed medication. I also understand that I may revoke this authorization with a written request. This consent also gives approval for the self-administration of over-the-counter medications to the participant pending the complaint of a nonurgent medical issue. Prior to dispensing any over-the-counter medications, the participant’s physician will be consulted regarding potential adverse reactions or interactions with prescribed medications.

**The above participant is allergic to the following:**

Executed this \_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

(Signature of Guardian or Authorized Representative) (Signature of Witness)

(Signature of Participant) (Participant Date of Birth)