NEW DAY, INC
ADMISSION PACKET

New Day, Inc
Day Treatment
1724 Lampman Dr.
Billings, MT 59101
Phone 406-256-3224
Fax 406-256-3219

New Day, Inc
P.O. Box 30282
Billings, MT 59107
Phone 406-254-2340
Fax 406-294-1023
www.newdayinc.org

New Day, Inc
Community Based SVC
1724 Lampman Dr. #2
Billings, MT 59102
Phone 406-294-2330
Fax 406-294-2332

Application for Services

Participant's Legal Name _____ Anticipated Date of Admission _____ Gender: M__F__

S.S.N. _____ Medicaid# or Tribal # _____ Date of Birth _____

Current Residence _____ Address _____

City _____ State _____ Zip _____ Phone # _____

Program(s) Applying For: Therapeutic Group Home ___ Day Treatment ___

Targeted Youth Case Management ____ Therapeutic Foster Care ___

Current DSM IV Diagnosis: _____

_____

Legal Guardian/Custodian _____ Relationship to Participant _____
(If guardianship is other than parent, provide court documents.)

Guardianship – please circle one: Temporary Permanent Joint

Guardian Address _____ City _____ State ____ Zip _____

Guardian Email Address _____

Community Case Manager _____ Agency _____

Address _____ City _____ State ____ Zip _____ Phone _____

Allergies: _____ **Allergies Action Plan:** _____

Name of person completing this form: _____ Phone _____

Please include the following information for admission packet completion:
Documentation of current custody/legal guardianship of youth.
Most recent psychiatric evaluation, chemical dependency records, social history and other pertinent clinical reports.
Any aftercare plans & discharge summaries.
Immunization records.
Copy of youth's Medicaid Card/ Insurance Info, Social Security Card, & Birth Certificate.
Education/School Records.

(Electronic file- Section 1- Application for Services)

New Day, Inc
Participant Information Sheet

1. **Name** _____ 2. **Gender** _____ 3. **Date of Birth** _____

4. ** Date of Placement/ Admission into New Day, Inc. _____

5. **Service Dates**:

Therapeutic Group Home-	Start Date _____	End Date _____	NA _____
Day Treatment Mental Health Center-	Start Date _____	End Date _____	NA _____
Co-Occurring Program-	Start Date _____	End Date _____	NA _____
Targeted Youth Case Management-	Start Date _____	End Date _____	NA _____
Therapeutic Foster Care-	Start Date _____	End Date _____	NA _____

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6. **Identifying Information**:

Birth Place _____ Race _____ Tribe & Enrollment # (if applicable) _____

Social Security # _____ Height _____ Weight _____ Gender ____ Religion _____

Legal Guardian of Youth _____ Phone # _____

Guardian Address _____ City _____ State ___ Zip _____

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7. **Contact Info on Parents**:

Father's Name _____ Mother's Name _____

Address _____ Address _____

City _____ State ____ Zip _____ City _____ State ___ Zip _____

Phone # _____ Phone # _____

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8. **Placement Agency**/ Referral source (Tribal Alcohol Program, IHS, Social Services, Hospital, etc.):

Referral Agency Name _____

Referral Address _____ City _____ State ___ Zip _____

Referral Source Contact Person Name _____ Phone # _____

Significant Others (Therapist, School Counselor) _____

Address _____ City _____ State ___ Zip _____ Phone# _____

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9. **Payment Source** (Medicaid, BIA Social Services, Probation, Tribal Alcohol, etc.) _____

Address _____ City _____ State ____ Zip _____

Person Responsible for Accounts Payable _____ Phone # _____

Private Insurance for Psychiatric and/or Medical Care Name _____

Insured Name _____ Social Security # _____ Group # _____

ID/Policy # _____ Address _____ City _____ State ___ Zip _____

Phone # _____ Signature of Insured _____ Date _____

(Electronic file- Section 1- Information Sheet)

(Continued next page)

New Day, Inc

Participant Information Sheet Continued

(Continued from previous page)

10. **Education:**

Name of Last School Attended _____ Grade ___ School Address _____

City _____ State ____ Zip _____ Phone # _____

11. **Youth Court Status:**

Is participant currently assigned a probation officer? Yes _____ No _____

Probation Officer Name & Agency _____

Probation Address _____ City _____ State ___ Zip _____

Probation Phone # _____

LEGAL HISTORY

Legal Status	Facility Detained	Arrests/Charges Filed	Date of Incarceration	Dates of Probation

Additional information (Contact Restrictions, etc.)

Completed by _____ Date _____

New Day, Inc
Contact Sheet

Participant _____ Date of Admission _____

Placing Agency _____ Case Manager _____

Probation Officer _____ City, State _____

Participant May Have Passes with the Following:

	Name	Relationship	Address	Phone
1.				
2.				
3.				
4.				
5.				

Participant May Have Visits with the Following:

	Name	Relationship	Address	Phone
1.				
2.				
3.				
4.				
5.				

Participant May Have Phone Contact with the Following:

	Name	Relationship	Address	Phone
1.				
2.				
3.				
4.				
5.				

- Anyone who is not on this list will not be allowed contact with the participant at Group Home/Day Treatment.

(Electronic file- Section 1- Contact Sheet)

New Day, Inc.

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_____

(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 _____

(Electronic file- Section 2- Signed Consents)

New Day, Inc
Day Treatment
1724 Lampman Dr.
Billings, MT 59101
Phone 406-256-3224
Fax 406-256-3219

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 _____

(Electronic file- Section 2- Signed Consents)

New Day, Inc

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) days 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.

Participant Name _____ DOB: _____

**Parent/Guardian Signature _____ Date: _____

Signature of Participant (for substance abuse records) _____ Date: _____

(Electronic file- Section 2- Signed Consents)

New Day, Inc

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Name of Participant _____ Date of Birth _____

Name of Facility Requesting Information From: _____

Address: _____ City _____ State ____ Zip _____

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 for Targeted Youth Case Management
- I authorize New Day, Inc., Targeted Youth Case Management 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
_____ Psychological Testing
_____ Progress Notes/Report
_____ Chemical Dependency Assessment Summary
_____ ACT Evaluation/Recommendation Report
_____ Other (Provide specific description of the information):

_____ Medication Records
_____ Psych/Social Information
_____ Treatment Plans
_____ Discharge Summary

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 patient.

3. 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 notice.
4. I understand that my records may be transmitted by fax.
5. This consent will expire 12 months from the date this authorization is signed
6. I have received a copy of this authorization.

Participant Name _____

**Parent/Guardian Signature _____ Date: _____

Signature of Participant (for substance abuse records) _____ Date: _____

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

New Day, Inc. Targeted Youth Case Management Staff accepting authorization: _____

(Electronic file- Section 2- Signed Consents)

New Day, Inc.

YOUR RIGHTS REGARDING PARTICPANT'S HEALTH INFORMATION

(guardian)

Name of Participant _____

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 _____ Date: _____

(Youth signature obtained on Rights Regarding Health Info in Youth Handbook *(electronic file- Section 2- Handbook)*).

(Electronic file- Section 2- Signed Consents)

New Day, Inc
NOTICE OF PRIVACY
(Guardian)

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: _____

(Youth signature obtained on Notice of Privacy in Youth Handbook *(electronic file- Section 2- Handbook.)*.

(Electronic file- Section 2- Signed Consents)

New Day, Inc
AUTHORIZATION FOR TREATMENT

The undersigned hereby authorize New Day, Inc., Billings, MT (hereinafter referred to as New Day, Inc.) to provide such routine medical care and treatment to _____ (participant) as the New Day, Inc. staff consider to be necessary and as established to an existing treatment plan.

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 participant prior to their use. Non-routine care and treatment or medications will not be administered to the participant without the undersigned and/or participant's prior 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. New Day, Inc will make every reasonable effort to notify the undersigned in advance of such treatment, unless doing so creates a life-threatening situation. Should more comprehensive emergency medical treatment be necessary, the undersigned consent to the transfer of the patient to a local general hospital facility for medical treatment.

**Parent/Guardian Signature _____ Date: _____

(Electronic file- Section 6- Authorization for Treatment)

New Day, Inc

MEDICATION AUTHORIZATION CONSENT

I, _____ authorize _____ to
(Name of Guardian) (Name of Program)

dispense to _____ the following medications, as prescribed by a state
(Name of Participant)

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 New Day, Inc. 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 New Day, Inc. 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 non-urgent 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: _____

Action Plan for allergy: _____

** Parent/Guardian Signature _____ Date: _____

Participant Date of Birth _____

(Electronic file- Section 6- Medication Authorization Consent)

New Day, Inc
Medical History
MEDICATION HISTORY

Medication Profile

Name of Participant _____

Date this form being completed: _____

***MUST ALSO INCLUDE NON-PRESCRIPTION MEDS, VITAMIN, SUPPLEMENTS, INHALERS, ETC.**

Current Medications:

Medication Name	Dose	Frequency	Begin/End Date	Side Effects	Helpful	Not Helpful

Past Medications:

Medication Name	Dose	Frequency	Begin/End Date	Side Effects	Helpful	Not Helpful

(Electronic file- Section 6- Medical History)

New Day, Inc.
Medical History
PSYCHIATRIC PLACEMENT/ TREATMENT HISTORY

All Mental Health Facilities/Out of Home Placements

Name of Participant _____

Date this form being completed: _____

In-Patient Treatment History

Admit & Discharge Dates	Name of Facility	Address	City	State	Zip	Phone #
1.						
2.						
3.						
4.						
5.						

Out-Patient Treatment History

Dates of Service	Name of Provider/ Agency	Counselor/ Psychiatrist Name	Type(s) of Service	Phone #
1.				
2.				
3.				
4.				
5.				

(Electronic file- Section 6- Medical History)

New Day, Inc
CUSTODY OF PARTICIPANT

Documentation of current custody/ legal guardianship of youth is accompanying this admission packet:

_____ Yes _____ No

If no, please explain why:

_____ Parents are guardians.

_____ Other reason: _____

_____ Date custody order is being sent: _____

Signature of person completing this form: _____

(Electronic file- Section 2- Custody Order/ Tribal Court Order)

New Day, Inc
ADDITIONAL REQUIRED RECORDS

The following are accompanying this admission packet:

_____ Medicaid Card/ Insurance Info.
_____ Copy of Social Security Card
_____ Copy of Birth Certificate
_____ Immunization Records
_____ Education/ School Records
_____ Further documents of most recent psychiatric evaluation, chemical dependency records, aftercare plans, discharge summaries, social history and other pertinent clinical reports.

Any of the above records not accompanying this admission packet, please explain why: _____

_____

_____

Date records are being sent: _____

Signature of person completing this form: _____

(Electronic file- Section 10- Record Request)

NEW DAY, INC
Targeted Youth Case Management
Intake Orientation/ Partnership Agreement

Services the client (youth and family) can expect from New Day, Inc.

A person can be considered a client if he/she is under the age of eighteen (18) or is over eighteen and still in school. Our services are provided to clients who meet clinical and financial eligibility requirements as set forth by the State of Montana; and other payers. Clients or families will not be refused services on the basis of race, color, creed, sex, national origin, political affiliation, or mental or physical disability.

All clients and families have the right to be treated with dignity and respect. New Day, Inc is committed to providing services that reflect that right. You will be provided services in a manner that complies with the Client's Rights.

New Day, Inc. will provide you with a Grievance Procedure to utilize if you feel your rights have been violated. The Grievance Procedure is available upon request.

New Day is dedicated to assisting guardians with referrals and transition to any service, regardless of the provider. You have the right to apply for Targeted Youth Case Management (TYCM) services with any Mental Health Center contracted provider in your area. As guardian, we may recommend to you that you approve a referral to additional New Day, Inc programs as determined by your treatment team. Similar services may be offered by other community providers, and as the guardian, it is your right to choose which service provider you prefer to be referred to. New Day, Inc. will provide you with agency information upon your request.

All services shall be provided in a manner that protects personal privacy and confidentiality, You will be asked to sign several releases of information that will allow your New Day TYCM to speak with other appropriate program staff about the participants treatment. This communication may be verbal or written and is restricted to issues that involve providing the most appropriate, effective and timely treatment available. You may revoke these releases at any time by written request. 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 release in response to this authorization prior to my written notice.

Our business hours are Monday through Friday from 8:00 am to 4:00 pm. However, your appointments and meetings can be arranged with you outside of those hours as needed and defended in your child's Service Plan. You will also develop a crisis response plan within your Service Plan. If you have question in regards to any crisis situation please respond to the numbers given to you on your Strengths Based Service Plan in the Crisis Response section. New Day, Inc. staff is available to you during regular business hours and through our on-call system to offer support and to help problem solve.

You may choose to terminate services voluntarily. We only ask that you first discuss this decision with your caseworker and document your request in writing. If you choose another provider, we will help you make that transition. Our goal is to advocate for the most appropriate care for the client and family.

Our goal of Targeted Youth Case Management is to empower parents/guardians to actively be involved with the treatment planning process. We encourage you to ask questions to help you understand your role in your child's treatment. We strongly believe that when a parent/guardian is invested in their child's treatment that it can only create a win-win situation for that child. We look forward to participating with you in the development of a Strengths Based Service Plan and creating a partnership with you and your child's treatment team.

Parent/Guardian Signature _____ Date _____

Targeted Youth Case Manager Signature _____ Date _____

CASE MANAGEMENT INFORMATION ONLY

(Electronic file- Section 2- TYCM Agreement)

NEW DAY, INC
Targeted Youth Case Management
Services

New Day, Inc. is currently providing Case Management Services to several areas in Montana. It is required by the State of Montana that parent/guardians be informed of other Youth Case Management providers.

These include:

- YBGR (Yellowstone Boys and Girls Ranch) – Community Bases Services
- Youth Dynamics, Inc
- AWARE, Inc.

As these service providers change you will be informed of changes.

Parent/Guardian Signature _____ Date _____

CASE MANAGEMENT INFORMATION ONLY

(Electronic file- Section 2- TYCM Services)

Medication Agreement

Introduction

I (**circle one**: patient or guardian of patient seeking treatment) am seeking healthcare services for the treatment of my psychiatric condition from Big Sky Psychiatric Services, P.C. I understand that treating my condition will require a plan/program involving psychiatric medication. There are numerous state laws, federal laws, and regulations regarding the use of prescription medications, specifically controlled substances. The purpose of this agreement is to help this healthcare practice and I comply with the laws and regulations. I understand this agreement will provide me with information about my treatment plan and the medications I am prescribed to help with my condition. I also understand that a trial on controlled substances may be considered for the intent of reducing psychiatric condition symptoms and increasing function.

The provider's goal is for me to have the best quality of life possible given the reality of my clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship, and full agreement and understanding of risks and benefits of using controlled substances to treat psychiatric conditions.

If you are the guardian of the patient seeking treatment, "I", "me", or "my" should be taken in the context of the patient you are signing on behalf of. I understand that by signing this form as the guardian of the patient, I am taking responsibility for this contract.

_____ (Initials)

Patient Disclosure of Current Medications and History of Substance Abuse

I will inform my physician of all medications I am taking as controlled substances can interact with over-the-counter medications and other prescribed medications.

I will not participate in the use of illegal drugs such as cocaine, methamphetamine, etc. while a patient at Big Sky Psychiatric Services P.C. A positive drug screen may results in termination of my psychiatric therapy. My provider may ask me to follow through with a program to address my substance abuse issue, should it arise, and may result in not being able to continue my care until such programs are completed. Programs include but are not limited to: 12-Step Program and Securing a Sponsor, Chemical Dependency Evaluation, Individual Counseling, Inpatient or Outpatient Treatment, etc.

_____ (Initial

Definition of a Single Provider and Single Pharmacy

I will receive psychiatric controlled substance medications **only** from Big Sky Psychiatric Services, P.C. and will not attempt to obtain any other psychiatric controlled substance medications from any other provider.

_____ (Initials)

I agree to only use my medications as prescribed and for the purpose prescribed. If I overuse my medications without my providers consent, loose my medications, or if my medications are stolen I understand that they will not be refilled early. I understand that if I consistently fail to keep scheduled appointments without 24-hours advance notifications my medication(s) will not be refilled.

_____ (Initials)

I will agree to use the same pharmacy to fill controlled substances unless I speak with the office staff about switching.

Pharmacy: _____
Location: _____
Telephone Number: _____

_____ (Initials)

If I receive psychiatric controlled substance medications from another provider while a patient at Big Sky Psychiatric Services, I will be dismissed from the practice.

_____ (Initials)

Information Consent on the Risk of Using Controlled Substances

Some possible side effects of psychiatric controlled substances:

- Drug interactions and possible toxicity
- Drowsiness, poor concentration, motor incoordination, visual changes, muscle weakness, vertigo, and mental confusion
- Memory impairment
- Increased excitement, irritability, aggression, hostility, and impulsivity
- Depression and emotional blunting
- Adverse side effects in pregnancy
- Tolerance, dependence, withdrawal
- Headache, upset stomach, increased or decreased blood pressure
- Decreased or increased appetite and/or weight loss or gain
- Nervousness or insomnia

Note this is not a complete list of the possible side effects, please read medication insert for further information regarding side effects of a specific medication.

These side effects may be worsened when controlled substances are mixed with other drugs, including alcohol.

_____ (Initials)

The following can occur with the use of controlled substances:

Controlled substance abuse is a primary, chronic neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the drug may have to be titrated up or down to a dose the produces maximum function and a realistic decrease of the patient's symptoms.

Physical Dependence means if the controlled substance is abruptly stopped or not taken as directed, a withdrawal symptom may occur. This is a normal physiological response. The withdrawal symptoms could include, but are not limited to: sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

_____ (Initials)

Self-report on Symptoms, Side-Effects, and Function at Follow-up Visits

I will communicate fully with my provider about the character and intensity of my symptoms, the effect of these symptoms on my daily life, and how well the medicine is helping to relieve my symptoms.

_____ (Initials)

Pregnancy

I understand the potential harm of many psychiatric medications to unborn children and agree to notify Big Sky Psychiatric Services, P.C. if I am, or become pregnant in the future.

_____ (Initials)

Consent to unannounced Drug Screen Tests or Pill Counts

I understand that I will consent to unannounced drug screening. A drug screen is a laboratory test in which a sample of my urine is checked to determine what drugs I have been taking. Refusal could be viewed as non-adherence to my regimen and this contract and could result in dismissal from the practice.

I may be asked to bring all unused medications, in the original containers, to my office visit. I will comply, when requested, to bring my medications to my appointment. Refusal could be viewed as non-adherence to my regimen and this contract and could results in dismissal from the practice.

_____ (Initials)

Definition of Terms of Non-compliance and Termination of Treatment

Evidence of misuse/abuse of any medication will result in tapering and/or discontinuations. Specific examples of misuse/abuse include injecting or snorting oral formulations; selling, giving away, or borrowing medications; and frequent dosage escalations despite warnings. I understand that these actions are also illegal. Other unacceptable activities include prescription forgery; obtaining drugs from non-medical sources; concurrent use of alcohol or illicit substances; repeatedly seeking prescriptions from other clinicians or emergency room departments; and repeated resistance to changes in therapy despite clear evidence of physical or psychological side effects.

I understand that my failure to meet these requirements may results in my provider choosing to stop prescribing medications for me. Withdrawal from specific medications will be coordinated by the provider and may require specific referrals.

_____ (Initials)

Patient Waiver of Privacy

I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency (including the state of residency's state Board of Pharmacy) in the investigation of possible misuse, sale, or diversion of my controlled substance medications. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

_____ (Initials)

Required Signatures

I affirm I have full right and power to sign and be bound by this agreement and that I have read, understand, and accept all of its terms. I understand violations of this medication agreement may result in dismissal from Big Sky Psychiatric Services P.C.

I have read this document, understand it, and have had all my questions answered satisfactorily. I agree to use the controlled substances prescribed to me to help with my psychiatric symptoms. I understand my treatment with these medications will be carried out in accordance with the conditions stated above.

I certify I have knowingly and willingly signed this contract.

_____ _____

Patient Name Date of Birth

_____ _____

Patient or Guardian Signature Date

Policy and Procedures

Cancellation/ No Show Policy: *Our goal is to provide quality individualized psychiatric care in a timely manner. No-shows, late arrivals, and cancellations result in an inconvenience to those individuals who need access to care.*

As our patient, it is your responsibility to attend all scheduled appointments on time. If you are unable to make your appointment you must notify one of our staff members at least 24 hours prior to the scheduled appointment time. Please utilize the scheduling line option on our phone to ensure optimal assistance. This allows us to have a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving the opportunity to re-book the now vacant appointment slot with another patient.

Please arrive 15 minutes prior to your scheduled appointment to allow adequate time to update and/or verify your demographics and insurance information, as well as to complete any and all paperwork. We understand that delays can happen, however these tasks need to be completed before your appointment to ensure you, other patients, and the providers are on time.

As stated above we ask that you notify our staff at least 24 hours prior to canceling your appointment. Late cancellations and no-shows will be counted against you. If a patient has 4 no-shows/late cancellations they will be sent a warning letter. If patient cancels or no-shows again after warning letter has been sent, patient will be sent a dismissal letter from this practice.

Please remember that conformation calls and texts are placed 2 days prior to your appointment are a courtesy; ultimately it is your responsibility to know your appointment time and date.

Prescription Refills: *It is your responsibility to notify the office in a timely manner when refills are needed. Approval of your refill may take up to 3 business days so please be courteous and do not wait to call.*

Prescription refills will not be handled after regular office hours or on weekends. Please have your pharmacy fax refill requests to our office rather than calling and requesting refills, unless it is a controlled substance. Controlled substances require monthly scripts; therefore they can be requested through our prescription refill line to ensure a timely response.

Our clinicians reserve the right to deny refills or reduce quantities and doses. Patient refills may also be denied if patients have not returned for follow-ups within the time frame agreed at the previous appointment and thus a follow-up appointment must be scheduled before refills are authorized.

Payment Agreement: *Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our financial policies, or your financial responsibilities do not hesitate to contact our billing department, MedWrite, at (406) 655-0980.*

As our patient, it is your responsibility to provide our office with your current insurance information at every appointment. To ensure this, we will ask for your insurance card at each office visit to keep our files updated with the correct information. If current information is not obtained at the time of service, it will become the patient's accountability to pay the entire balance until current information is provided to our billing office.

Co-payments are due at the time of check in at the front desk PRIOR to you being seen by our providers. Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

Cash pay patients are to make payment arrangements 2 weeks prior to scheduled appointments.

All unpaid and outstanding balances are asked to be paid in full at the time of service, unless prior arrangements have been made through our billing office. If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. You may call our billing office to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity.

You are ultimately responsible for the timely payment of your account.

By signing below, you acknowledge that your received this notice and understand these policies.

_____	_____
Patient Name (please print)	Patient Date of Birth
_____	_____
Patient/Responsible Party Signature	Date

NOTICE OF PRIVACY

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

Our Commitment to your privacy: Our organization is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances: The following circumstances may require to use or disclose your 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 your health and safety or the health and safety of another individual, or the public. We will only make disclosures to a person organization able to help prevent the threat.
5. If you are a member of the US 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 you are an inmate or under the custody of law enforcement official.
8. For workers compensation and similar programs.
9. You authorize the release of any medical records, pictures or other information to medical professionals necessary to pre-certify procedures, process medical claims or for continuity care.

Your rights regarding your health information:

1. Communications. You can request that our organization communicate with you about your 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 at work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request however if we do we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient billing records, but not psychotherapy notes. You must submit your request in writing to BIG SKY PSYCHIATRIC SERVICES, P.C..
4. You may ask us to amend your 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 BIG SKY PSYCHIATRIC SERVICES, P.C.. 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 BIG SKY PSYCHIATRIC SERVICES, P.C..
6. Right to file a complaint. If you believe your rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact BIG SKY PSYCHIATRIC SERVICES, P.C.. All complaints must be in writing. You will not be penalized for filling a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice 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 question regarding this notice or our health information privacy policies, please contact BIG SKY PSYCHIATRIC SERVICES, P.C. in writing at 820 Division Street, Billings, Mt 59101, I herby acknowledge that I have been presented with a copy of, BIG SKY PSYCHIATRIC SERVICES, P.C., Notice of Privacy Practices.

Patient Name (Please Print):_____ Date: _____

Signature of Patient or Patient's Representative: _____

Disclosure of Privacy

Printed name of patient: _____ DOB: _____

Printed name of patient's representative: _____

Relationship to patient: _____

USE/RESTRICTION OF PATIENT INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Phone:** _____
- ☐ O. K. to leave message with detail information
- ☐ Leave message with call-back number only

☐ **Work Telephone:** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cell Phone:** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication**
- ☐ O.K. to mail my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K to fax to: _____

☐ **Verbal Communication**
- ☐ O.K. to release information verbally to:

_____

_____

_____

It is the patient's responsibility to provide updates or changes to this information.

I herby acknowledge that I have reviewed a copy of Big Sky Psychiatric Services, P.C. Disclosure of Privacy Summary.

_____ _____

Signature of patient or patient's representative **Date**

The privacy rule generally requires health providers to take reasonable steps to limit the use or disclosure of requests for PHI to the minimum necessary to accomplish the intended purpose. These provision do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for Treatment, Payment, Healthcare Operation (TPO) may be permitted without prior consent in an emergency.

INTAKE FORM

Please provide the following information about yourself. This information will help us better understand the problems that you are having. This information is confidential and will not be released to anyone without your written permission.

Name: _____ **Date:** _____

Name of person filling out form (if different than above) and relationship to patient:

_____

_____

Problems you are having: Please mark which of the following problems applies to you.

- ❑ excessive worry
- ❑ sleep problems
- ❑ appetite problems
- ❑ mood problems
- ❑ feeling hopeless, guilty, worthless
- ❑ fatigue or energy
- ❑ loss of interest in activities
- ❑ suicidal thoughts
- ❑ self harm
- ❑ recent (within 2 months) change in weight
- ❑ trouble staying focused
- ❑ trouble with memory
- ❑ hyperactivity or too much energy
- ❑ behaviors that are out of character (e.g. excessive repeated actions or thoughts you can't stop, spending, gambling, or increased sexual activity)
- ❑ seeing or hearing things others do not
- ❑ feeling suspicious
- ❑ eating disorder
- ❑ panic attacks
- ❑ anger problems
- ❑ alcohol problems
- ❑ drug problems
- ❑ difficulties and work and/or school
- ❑ death of a loved one
- ❑ relationship problems
- ❑ gambling problems
- ❑ sexual problems
- ❑ other

  _____

  _____

  _____

Please list sources of stress (things/events/problems that are creating stress in your life at the present time, include significant losses and changes in your life).

_____

_____

_____

Please list the goals that you hope to achieve through psychiatric care. Be as specific as you can.

_____

_____

_____

On a scale of 0-10 (0 being the worst you have ever done/felt and 10 being the best you have ever done/felt) please circle the number that indicates your current functioning.

0 1 2 3 4 5 6 7 8 9 10

History of Abuse (please circle all that apply):

Emotional	none	past	ongoing
Sexual	none	past	ongoing
Physical	none	past	ongoing

History of Psychiatric Hospitalization:

Date	Hospital	Reason

❑ **Check here if none/not applicable**

History of Suicide Attempts:

Date	What method

❑ **Check here if none/not applicable**

Current or Previous Counseling or Outpatient Psychiatric Care:

Name of Therapist or Agency	Date and Focus of Sessions

❑ **Check here if none/not applicable**

Background Information

Were you raised by your natural parents? Yes:_____ No:_____

Describe family dynamics while you were growing up:

_____

_____

_____

_____

_____

_____

Describe any important events of your childhood and adolescence. For example: death of a family member, desertion by parents, divorce, abuse, alcoholism or mental illness of a family member. **Please indicate the age you were when the events occurred.**

_____

_____

_____

_____

Name PRESENT family and household members, with ages:

_____

_____

_____

EDUCATION:

How many years of school have you completed?_____

Describe any important learning or behavior problems you had in school:

_____

_____

_____

PATIENT MEDICAL and SURGICAL HISTORY (please check all that apply):

MEDICAL HISTORY

- ❑ Cancer
- ❑ Diabetes
- ❑ Seizures/Epilepsy
- ❑ HIV
- ❑ Heart Attack/Abnormal Rhythm
- ❑ Emphysema/COPD
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Thyroid Disease
- ❑ Head Injury
- ❑ Hepatitis
- ❑ Asthma
- ❑ Sleep Apnea
- ❑ NONE

SURGICAL HISTORY

- ❑ Appendix
- ❑ Tonsils
- ❑ Heart Surgery
- ❑ Gallbladder
- ❑ Thyroid
- ❑ Intestinal
- ❑ Hernia
- ❑ Tubal
- ❑ C-Section
- ❑ Vasectomy
- ❑ Weight Loss Surgery
- ❑ NONE

LIST ANY OTHER DISEASES, MEDICAL HISTORY or SURGICAL HISTORY:

_____

_____

Are you currently experiencing any pain? (please check one): ☐ Yes ☐ No

If yes, where is the pain and how long have you had it?

_____

How would you rate the pain on a scale of 1-10? (0=no pain, 10=worst pain of your life)

_____

Who is your primary care provider?_____

Are you currently experiencing any of the following (please check all that apply):

- ❑ fever/chills
- ❑ night sweats
- ❑ headache
- ❑ dizziness
- ❑ tremor
- ❑ blurry vision
- ❑ dry mouth
- ❑ chest discomfort
- ❑ racing heart
- ❑ shortness of breath
- ❑ nausea
- ❑ muscle/joint pain

FAMILY HISTORY: *(CHECK ALL THAT APPLY –OR-**INDICATE UNKNOWN/NONE**)*

	Heart Disease	Respiratory/Lung Disease	Diabetes	Thyroid Disease	Cancer	Unknown/None
Father						Unknown None
Mother						Unknown None
Siblings						Unknown None
Grandparents						Unknown None
Children						Unknown None

Family History, Other/Additional:

_____

_____

_____

FAMILY HISTORY of MENTAL HEALTH PROBLEMS: *(CHECK ALL THAT APPLY – OR-**INDICATE UNKNOWN/NONE**)*

	Depression	Anxiety	Psychosis or Schizophrenia	Bipolar Disorder	Drug or Alcohol Problems	Suicide Attempts	Committed to a state psychiatric hospital	None Or Unknown
Father								Unknown None
Mother								Unknown None
Siblings								Unknown None
Grandparents								Unknown None
Children								Unknown None

Family History of Mental Health Problems, Other/Additional:

_____

_____

SOCIAL HISTORY

Marital Status (please check one):

- ❑ Married
- ❑ Partnered
- ❑ Single
- ❑ Divorced
- ❑ Widowed

Work History:

___ Employed ___ Unemployed ____ Disabled ____ Retired

Current Occupation/Employer:

_____

_____

(List amount, frequency or past dates of use. If none, indicate none) :

TOBACCO USE:_____

ALCOHOL USE:_____

USE OF "RECREATIONAL DRUGS":_____

CAFFEINE INTAKE:_____

Do you have any legal charges? (please check one):

- ❑ Yes
- ❑ No

If yes, please indicate what charges, when it occurred and sentencing:

_____

_____

Are you currently on probation or parole? (please check one):

- ❑ Yes
- ❑ No

If yes, name of probation/parole officer:_____

Military History:

Veteran (circle one): YES NO

Date of service:_____

If so, what branch:_____

Type of discharge:_____