



RESIDENTIAL TREATMENT APPLICATION CHECKLIST

A completed residential treatment application is to include the following 5 items:

- (1) Demographics**
- (2) Medical Clearance, TB, Medication Self-Administration Form.** All of these forms MUST be filled out by a qualified Health Care Provider. The Medication self-administration form must be completed prior to admission; Medical and TB forms preferred completion within past 30 days, mandatory completion within 2 days of program admission (Upon program approval).
- (3) Behavioral Health Assessment** – The assessment must be completed within past six months. Comprehensive Biopsychosocial Substance Abuse assessment to include DSM-5-TR and ASAM-3rd edition diagnoses with treatment recommendations requiring level 3.5 level of care. If an assessment has not already been completed, you may contact the Akeela Assessment Center at (907) 433-7080 to schedule one.
- (4) Releases of Information (ROI)** - Include a separate signed ROI for each of the parties involved in the applicant's case, i.e., physician, attorney, parole officer, counselor, OCS, etc. A separate ROI is required for each person and each agency that requires communication from the program and client.
- (5) If on probation or parole,** please provide a copy of the **Presentence Report.**
- (6) Children's Profile – **Stepping Stones Only ****

Once the above items are completed, you may fax or email the completed documentation to the designated Akeela Residential Treatment Program. Each Residential Treatment Program's contact information is listed below:

Akeela House:

Phone (907) 561-5266; Fax (907) 562-5041

Email: AkeelaHouseIntake@akeela.org

Stepping Stones:

Phone (907) 569-0097; Fax (907) 569-0098

Email: SteppingStonesIntake@akeela.org



RESIDENTIAL TREATMENT PROGRAM OVERVIEW

Thank you for your interest in Akeela's Residential Treatment Program. We're hopeful that this is the first step toward a healthier, brighter future for you. Before proceeding with your application to Akeela's Residential Treatment Program, please carefully read the following information:

The residential treatment programs at Akeela are designed to support individuals in their journey toward recovery. Our residential programs require full commitment and participation to ensure the best outcomes for each client. It is important that you understand the residential program's requirements, expectations, and the support available to you throughout treatment at Akeela.

Program Duration

Akeela's Residential Treatment Programs are long-term programs designed to support individuals struggling with addiction. Our residential treatment programs operate seven days a week and typically lasts between 6 to 9 months, with some instances extending up to 12 months. Throughout this time, our dedicated and professional clinical treatment team will guide your care and support your recovery journey. Each of our residential facilities varies in bed capacity, ensuring we can provide personalized care in a therapeutic environment.

Relevant Assistance Programs

To help manage the costs associated with residential treatment and living expenses, clients are required to apply for relevant assistance programs, including ATAP, TANF, supplemental nutritional assistance programs (SNAP), daycare assistance, cash assistance, and Medicaid. These benefits play an important role in covering essential expenses during treatment.

Materials Provided

All necessary program materials, such as paper and pens, will be supplied by Akeela.

Medication Policy

Any unauthorized medications, prescription or otherwise, will be confiscated and properly disposed of. Authorized medications will be managed in accordance with your treatment plan.

Substance Use Policy

Total abstinence from all mood-altering substances is required, except for prescribed medications. This is essential to maintaining a sober and supportive environment.

Dress Code

Please wear comfortable and appropriate clothing at all times. Clothing must not display alcohol or drug logos, and no revealing attire is allowed. Socks and shoes are required at all times, and sleeveless tops, tank tops, and open-toed shoes are not permitted in group sessions or outside your apartment. During business hours, sweats and shorts are not allowed.

Personal Care Items

Shampoos, mouthwash, hairspray, or other personal care products containing alcohol are prohibited.

Parking

Residential client parking is not available. Please do not bring a vehicle to the program.



Tobacco-Free Environment

Akeela's Residential Treatment Programs are completely tobacco-free. Tobacco products, including vapes and e-cigarettes, are **not permitted** on the premises. Smoking cessation support is available, including programs like QuitLine, and staff can help you arrange calls to QuitLine.

Orientation Period

Upon admission, a 14-day orientation period is in place to help you acclimate to the program. During this time, you will receive support from peers in the therapeutic community while reading the program handbook and orientation materials. Only business-related phone calls (e.g., OCS, attorney, PO) and communication with your children will be allowed during the 14-day orientation period. Staff may assist with approved visits and phone calls during this period.

Phone Calls and Messages

Supported phone calls will be available after you complete the orientation period. Our staff can pass on messages to residents. In case of emergency, your family will be provided with a staff contact number to reach you.

Visitation Policy

We believe in the importance of involving supportive family and friends in the recovery process. After the orientation period, visitors are welcome and encouraged. However, they must first attend a visitation orientation group and participate in a meeting with the client's primary counselor.

RESIDENT RESPONSIBILITIES & ADDITIONAL INFORMATION

Health and Readiness for Admission

To be admitted into the program, you must be physically and mentally stable enough to participate in treatment. If you arrive under the influence of alcohol or other substances, or if you are in withdrawal and require clinical intervention, you will be referred to an appropriate detoxification facility before entering our program.

Responsibility for Personal Costs

Akeela's Residential Treatment Programs are not responsible for transportation or any personal expenses you may incur during treatment. This includes costs for approved medications, personal items, and other necessary expenses.

Medication Requirements

If you are taking prescribed medications, please bring them with you in their original prescription bottles. Each medication must have the original pharmacy label with the prescription details. Medications cannot be mixed together in other containers or pill organizers.

Treatment Fees and Payment

Treatment fees are determined using a sliding fee scale based on your income and family status, in accordance with federal poverty guidelines. This ensures that fees are fair and appropriate to your financial situation.



RESIDENTIAL APPLICANT RESPONSIBILITIES AGREEMENT

By submitting your application for residential treatment at Akeela and signing below, you acknowledge that:

- I agree that the information provided by me in development of the Behavioral Health assessment, history and physical, and other intake paperwork is true and accurate to the best of my knowledge.
- I have signed an enclosed Release of Information to obtain further information that is necessary to determine my suitability for treatment and/or to confirm I will be reporting for treatment at my designated Akeela, Inc. Residential Treatment Program as scheduled.
- I have also signed a Release of Information, which authorizes my medical provider to release to my designated Akeela Residential Treatment Programs, medical information which is required to assess my suitability for acceptance and admittance into the residential treatment program.
- Other Releases of Information may also be required from other agencies (DOC, Courts, OCS, etc.) should also be signed for a comprehensive understanding of your appropriateness for our program.
- I have read the **Residential Treatment Program Overview** and agree to the enclosed **Residential Applicant Responsibilities Agreement**

APPLICANT SIGNATURE	DATE



BEHAVIORAL HEALTH TREATMENT REGISTRATION FORMS

Please Select ALL Akeela Service(s) of Interest:

- | | |
|---|--|
| <input type="checkbox"/> Assessment Center | <input type="checkbox"/> ADIS |
| <input type="checkbox"/> Outpatient – Mental Health | <input type="checkbox"/> Outpatient – Substance Use |
| <input type="checkbox"/> Residential – Akeela House | <input type="checkbox"/> Residential – Stepping Stones |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Medication Management |

FIRST NAME			
MIDDLE NAME			
LAST NAME			
MAIDEN NAME			
DATE OF BIRTH		AGE	

CONTACT INFORMATION			
MAILING ADDRESS			
CITY			
STATE & ZIP CODE			
PRIMARY PHONE NUMBER	()		
	We can leave a message on primary phone? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SECONDARY PHONE NUMBER	()		
	We can leave a message on secondary phone? <input type="checkbox"/> YES <input type="checkbox"/> NO		
EMAIL ADDRESS			
	It is OK to receive email at the address above? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SOCIAL SECURITY NUMBER			

DEMOGRAPHICS			
GENDER		RACE & ETHNICITY	
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary or Non-confirming <input type="checkbox"/> Prefer not to respond		<input type="checkbox"/> Alaskan Native or American Indian (select below) <input type="radio"/> Aleut <input type="radio"/> Athabascan <input type="radio"/> Haida <input type="radio"/> Inupiat <input type="radio"/> Tlingit <input type="radio"/> Tsimshian <input type="radio"/> Yupik <input type="radio"/> Other Tribal Affiliation: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or Northern African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White (select all that apply)	
MARITAL STATUS		PREFERRED LANGUAGE	
<input type="checkbox"/> Cohabiting <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> ASL <input type="checkbox"/> Other, list: Interpreter Needed: <input type="checkbox"/> YES <input type="checkbox"/> NO	



PAYER INFORMATION	
PRIMARY PAYER/INSURANCE	SECONDARY PAYER/INSURANCE
<input type="checkbox"/> AK Medicaid <input type="checkbox"/> None/Self Pay <input type="checkbox"/> Sliding Scale/Income Based <input type="checkbox"/> Other - If other, specify	<input type="checkbox"/> I Have a Secondary Payer/Insurance Name of 2nd Insurance Provider: <input type="checkbox"/> No Secondary Payer/Health Insurance

TREATMENT NEEDS
In your own words, please tell us about why you are interested in behavioral health services with Akeela.

SUD AT-RISK IDENTIFIERS	
If female, are you pregnant? (select one)	<input type="checkbox"/> YES Your Due Date: <input type="checkbox"/> NO <input type="checkbox"/> Does not Apply
Have you ever injected drugs? (select one)	<input type="checkbox"/> YES Date of Last Use: <input type="checkbox"/> NO
Do you use tobacco products? (select one)	<input type="checkbox"/> YES If YES, select type <input type="checkbox"/> NO <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Vape <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless
Are you participating in Opioid Replacement Therapy? (select one)	<input type="checkbox"/> YES Agency/Provider Name: <input type="checkbox"/> NO

REFERRAL SOURCE		
Please select who referred you to Akeela for behavioral health services.		
<input type="checkbox"/> ASAP <input type="checkbox"/> Department of Corrections, Court, or Probation <input type="checkbox"/> Detox Provider <input type="checkbox"/> Emergency Department <input type="checkbox"/> Friends or Family	<input type="checkbox"/> Office of Children Services <input type="checkbox"/> Other Outpatient Provider <input type="checkbox"/> Other Social Service Agency <input type="checkbox"/> Other Residential Program <input type="checkbox"/> Private Attorney	<input type="checkbox"/> Alaska Psychiatric Institute (API) <input type="checkbox"/> Medical Provider <input type="checkbox"/> Therapeutic Court <input type="checkbox"/> Self <input type="checkbox"/> Other (Please List):

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE



MEDICAL & MEDICATION for SELF-ADMINISTRATION CLEARANCE

Akeela's residential treatment programs do not administer medications to residents. However, we ensure all medications are safely stored so that residents can self-administer their prescribed medications as directed by their healthcare provider.

In accordance with the State of Alaska regulations, residents entering a residential treatment program where self-administration of medication is required must obtain medical clearance from a physician, Physician Assistant (PA), or Advanced Nurse Practitioner (ANP). This clearance must confirm that the individual is capable of safely self-administering their prescribed medications.

To complete your application for Akeela's residential programs, the following steps are required:

1. Medical Clearance Form:

Your medical provider must complete the Medical Clearance Form. This document is necessary to ensure your application is complete.

2. Self-Administration of Medication Form:

Your medical provider and/or prescribing provider must complete the Self-Administration of Medication Form. This is also required for your application to be finalized.

Thank you for ensuring these requirements are met as part of your application process.

I have read the above information regarding medical and medication clearance.	
APPLICANT SIGNATURE	DATE



MEDICAL CLEARANCE FORM

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PATIENT'S FULL NAME	DATE OF BIRTH

The following medical information form **MUST** be completed by a qualified health care provider in order to participate in Residential Treatment at Akeela.

Does this patient require detoxification prior to entering residential treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does this patient have any physical impairments and/or limitations? If YES, please explain:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does this patient have any communicable disease(s)? If YES, please explain:	<input type="checkbox"/> YES <input type="checkbox"/> NO
If applicable, is this patient pregnant? <input type="checkbox"/> Not Applicable	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please provide additional details:	

PHYSICAL EXAMINATION

SYSTEMS	NORMAL	ABNORMAL
Abdomen		
Cardiovascular		
Extremities		
Genitals		
Lungs		
Neck/Thyroid		
Neurological		
Skin		
Vital Signs		

TB CLEARANCE

SKIN TEST	
Administered Date:	
Read Date:	
Results:	mm <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE
X-RAY (If applicable)	
Results:	



MEDICAL CLEARANCE FORM

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ADDITIONAL INFORMATION FOR MEDICAL CLEARANCE

This patient has been medically evaluated and cleared to participate in residential treatment which may include groups and other activities up to 8 or more hours per day.		<input type="checkbox"/> YES <input type="checkbox"/> NO
If NO, please explain:		
Is this patient in psychiatric crisis?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please explain:		
Has this patient reported any recent suicidal ideation or homicidal ideation?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please explain:		
Does this patient have a regular Primary Care Provider?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please list:		
Does this patient have a regular Behavioral Health Provider?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please list:		

CLINIC INFORMATION

Name of Clinic:	
Clinic Phone Number:	
Clinic Address:	

As a qualified health professional, I attest that the information provided is accurate and complete to the best of my knowledge and professional judgment.

Signature of Healthcare Professional	Credentials	Date



MEDICAL CLEARANCE FOR SELF-ADMINISTRATION OF MEDICATION

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PATIENT'S FULL NAME	DATE OF BIRTH

The person listed below is requesting substance use disorder treatment at a residential treatment program of Akeela, Inc. The residential treatment program does not administer medications, but instead safely stores medications so that clients can then take their own medication (self-administration) as prescribed by their prescriber.

- ❖ In keeping with regulations by the State of Alaska, persons entering residential treatment in which clients take their own medication require a medical clearance from a physician, PA or ANP that states the client is capable of self-administration of medication prescribed.
- ❖ If you have questions, please contact one of our Residential Program Managers.

Akeela House:

Phone (907) 561-5266 • Fax (907) 562-5041 • Email: AkeelaHouseIntake@akeela.org

Stepping Stones:

Phone (907) 569-0097 • Fax (907) 569-0098 • Email: SteppingStonesIntake@akeela.org

MEDICATION LIST FOR CLIENT

Name of Medication	Prescriber	Dosage	Route	Frequency
If the patient is prescribed addictive or narcotic medications are there non-narcotic alternatives?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, please list:				

SELF ADMINISTRATION OF MEDICATION

The person named above is capable of self-administration of medication prescribed.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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CLINIC INFORMATION

Name of Clinic:	
Clinic Phone Number:	

As a qualified health professional, I attest that the information provided is accurate and complete to the best of my knowledge and professional judgment.

Signature of Healthcare Professional	Credentials	Date



FINANCIAL CONSENT

State grants, contracts and client fees fund Akeela treatment programs.

Clients will be charged a fee according to their ability to pay, however, no one will be denied services because of an inability to pay. This fee will be based on your annual gross family income and the number of people dependent upon that income. **All services are rendered without exclusion or discrimination on the grounds of race, color, creed, national origin, or disability.**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND PAYMENT OF MEDICAL BENEFITS TO Akeela, Inc. Akeela, Inc. will restrict disclosure to reasonably necessary information. This means Akeela, Inc. will **only** communicate limited information to insurance companies when it is reimbursed (pursuant to 42, CFR part 2).

Fees must be paid at the time of the appointment unless other arrangements have been made. Missed appointments may be billed at a flat rate of \$30.00 unless cancelled at least 24 hours in advance.

This is to certify that the above information is true and accurate to the best of my knowledge, and that I will be respectful for all financial obligations according to my set fee, which was established in my presence.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE

AKEELA STAFF SIGNATURE	DATE



REFUND POLICY

- Akeela does not provide refunds for any monies paid. **NO EXCEPTIONS.**
- Akeela does not perform assessments on individuals under the influence of Drugs and/or Alcohol. If you arrive and are under the influence, your appointment may be re-scheduled but there will be no refund tendered.
- This includes pre-paid assessments. It is **your** responsibility to follow through with appointments.
- There is a \$30.00 missed appointment fee if the appointment is cancelled or re-scheduled within 24 hours or if you do not show or call in for your appointment. This fee will be payable when you arrive for your assessment.
- If you have any questions or concerns, please contact Shannon Greig, Chief Financial Officer, (CFO) at 907-565-1200 ex 7019.

My signature below signifies that I have read and understand Akeela's Refund Policy.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE

AKEELA STAFF SIGNATURE	DATE



TREATMENT PROGRAMS FINANCIAL INFORMATION AND RELEASE

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CLIENT INFORMATION		
LAST NAME	FIRST NAME	MIDDLE NAME
EMPLOYER/SCHOOL	OCCUPATION	

**A COPY OF YOUR PRIMARY & SECONDARY INSURANCE IS REQUIRED
(INCLUDING MEDICAID) (COPY FRONT AND BACK OF CARD)**

PERSON RESPONSIBLE FOR THE ACCOUNT		
SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SOCIAL SECURITY#	
MAILING ADDRESS	CITY	
ZIP CODE	PHONE NUMBER	

PRIMARY HEALTH INSURANCE INFORMATION	
PRIMARY INSURANCE COMPANY	
MEMBER ID#	GROUP ID#

SECONDARY HEALTH INSURANCE INFORMATION		
IS CLIENT COVERED BY ADDITIONAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S LAST NAME (Responsible Party)	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SOCIAL SECURITY #	
MAILING ADDRESS	CITY	
ZIP CODE	PHONE NUMBER	
SECONDARY INSURANCE COMPANY		
MEMBER ID#	GROUP ID#	

**I authorize the individual below to contact Akeela on my behalf regarding financial payments only.
Copy of signed ROI must be on file.**

NAME	RELATIONSHIP	PHONE NUMBER

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE



TREATMENT PROGRAMS FINANCIAL INFORMATION AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and _____ therefore, assign directly to Akeela, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

RELEASE OF INFORMATION:

The following specific information: Required documentation and information for payment of service provision invoices for care received from _____ Admission _____ to _____ Discharge _____

The purpose of the release of this information is: Payment of Invoices for services rendered.

I understand that the information in my health record may include information relating to behavioral or mental health services and/or treatment for alcohol and drug abuse. It may also include information about acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it will not have any effect on actions taken on this authorization before my revocation was received. I understand that the individuals(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (If applicable) or eligibility for benefits on whether I provide this authorization, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 CFR pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken based upon it, and that in any event this consent expires automatically as of 12 months post discharge.

By my signature below I indicate that I have read this document, or have had it read to me, that I fully understand its meaning, that I have consented to its terms knowingly and voluntarily, and that I have not been under any undue duress or influence of alcohol or drugs in making this agreement.

Table with 4 rows and 2 columns: Client or Personal Representative Signature, Date, Printed Name of Personal Representative, Description of Personal Representative's Authority, Akeela Staff Signature, Date.

REVOCAION OF RELEASE:

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

I revoke the authorization to release information to _____ and/or _____ health insurance companies, effective: _____ (date).

Table with 4 rows and 2 columns: Client or Personal Representative Signature, Date, Printed Name of Personal Representative, Description of Personal Representative's Authority.



AKEELA FEE SCHEDULE

Behavioral Health Services Fee Schedule – Effective 01/01/2025

CLIENT'S FULL NAME	CLIENT DATE OF BIRTH

All clients are responsible for full payment of services provided to them by Akeela, Inc at the time service is provided.

Screening/Assessments (Sliding Fee Scale does not apply)

Assessment Screening Tool	\$ 145.00	per assessment	No SFS	Included in Assessment price below
Integrated MH / SU Intake Assessment	\$ 750.00	* per session	No SFS	* \$150 Discount when paid in full at time of service
Alcohol / Drug Assessment	\$ 530.00	* per session	No SFS	* \$150 Discount when paid in full at time of service
Mental Health Intake Assessment	\$ 670.00	* per session	No SFS	* \$150 Discount when paid in full at time of service
Psychiatric Assessments - By MD, PA ,ANP only	\$ 675.00	per session	No SFS	

Clinic Services - Mental Health

Individual / Family Psychotherapy	\$ 170.00	per hour	
Group Psychotherapy	\$ 80.00	per hour	
Multi-Family Psychotherapy	\$ 120.00	per hour	
Crisis Intervention / Stabilization	\$ 150.00	per hour	
Pharmacologic Management	\$ 180.00	per occurrence	No SFS

Rehab Services - Substance Use

Individual / Family Services	\$ 145.00	per hour
Group Services	\$ 80.00	per hour
Treatment Plan Development / Review	\$ 155.00	per occurrence

Residential Services (Sliding Fee Scale does not apply)

Akeela House	\$ 18.25	per Bed/day	Submission of Quest Card Required
Stepping Stones	\$ 13.34	per Bed/day	

Other Services (Sliding Fee Scale does not apply)

No Show Fee	\$ 30.00	per occurrence	No SFS
ADIS Class	\$ 150.00	per 3 day class	No SFS

Sliding Fee Scale discounts available to self-pay clients that qualify.

If you would like to apply for a SFS, please ask for assistance.

Proof of income, along with completed and signed Sliding Fee Scale paperwork, is required to receive a Sliding Fee Scale discount. All clients will be billed at a 100% fee for services provided to them until financial documentation is reviewed and approved by billing department staff. Sliding Fee Scale discounts are available to self-pay clients only and will take effect as of the first day of the month in which acceptable proof of income is received.

As a courtesy, Akeela will bill and collect from all other sources of insurance first before billing the client for the balance. Proof of valid insurance required prior to billing of insurance. This includes all private insurance as well as Denali Care/Denali Kid Care (Medicaid). Akeela is not in network with any private insurance companies. Insurance coverage and/or payment depends on each individual policy and is not guaranteed.

Clients must bring in their insurance card if they wish to have Akeela bill their insurance. Denali Care/Denali Kid Care (Medicaid) is insurance. Insurance will only be billed providing all required paperwork is completed and signed. Insurance billing will begin as of the first day of the month in which proof of valid insurance is received.

I have received a copy of the above Fee Schedule and agree to the above rates and terms.

Client, Parent, or Guardian Signature	Parent or Guardian Name	Date

I hereby assign my benefits payable for services provided to me, by Akeela, Inc., be remitted to Akeela, Inc.

Client, Parent, or Guardian Signature	Parent or Guardian Name	Date



NOTICE OF PRIVACY PRACTICES

Page 1 of 2

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective September 1, 2020 and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are several situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, and health care operations requires you to sign an Authorization. Certain disclosures are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our agency once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities and arranging for legal and auditing functions.

Health Information Exchange Organization: Federal and state laws permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes and such other purposes as may be permitted by law. You can **opt-in** for participation in this database.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceeding and in the event of death.

We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law enforcement official's information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We may contact you from time-to-time to provide appointment reminders or information about treatment. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others. Specifically, there are eight reasons when we can disclose the minimum necessary client information:



NOTICE OF PRIVACY PRACTICES

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1. To qualified business associates with a business associate agreement in place	2. To State or Federal auditors or in the process of research
3. To medical providers in a medical emergency	4. To report child abuse or neglect
5. To another Akeela, Inc. personal	6. To report a crime committed on Akeela's premises or against Akeela's personnel
7. Suicidal or homicidal threats or attempts	8. As allowed by an authorizing court order

You have certain rights regarding your health information, as follows:

You may request that we restrict the uses and disclosures of your health record information for treatment, payment, and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to the above noticed exceptions, disclosures of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in civil, criminal, or administrative action or proceeding to which your access is restricted by law. We may charge a reasonable fee for providing a copy of your health records or a summary of those records at your request, which includes the cost of copying, postage, and preparation of an explanation or summary of the information.

All requests for inspection, copying and/or amending information in your health records and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you at your request.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer at Akeela, Inc. or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site: <http://www.hhs.gov/ocr/hipaa>

ALL QUESTIONS CONCERNING THIS NOTICE OR REQUESTS MADE PURSUANT TO IT SHOULD BE
ADDRESSED TO: AKEELA, INC.
ATTN: PRIVACY OFFICER,
360 W. BENSON BLVD. SUITE 300,
ANCHORAGE, AK 99503
(907)565-1200



CLIENT RIGHTS

1. Each client's rights are to be respected by Akeela and its staff.
2. A client has the right to get information supplied and explained in a manner understood.
3. A client has the right to be a part of the decision making and planning of treatment, care, or services.
4. A client has the right to give or withhold permission for recordings, films, pictures, videos, or other images of him/her to be taken or released for purposes other than their care.
5. A client's rights to be protected during research, investigation and clinical trials are to be respected by Akeela and its staff.
6. A client has the right to receive information on the staff providing care, treatment, or services, such as qualifications, gender, education, experience.
7. A client has the right to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.
8. A client has the right to be in an environment that preserves dignity and contributes to a positive self- image.
9. A client continues to have the right of all citizenship privileges including non-discrimination in receiving services.
10. A client has the right to access protective and advocacy services.
11. Akeela protects the rights of those served who work for or on behalf of Akeela.
12. Akeela staff will inform each client of their responsibilities related to their care, treatment, or services.
13. A client has the right to participate in formulating, evaluating and periodically reviewing their individualized written treatment plan, including requesting specific forms of treatment, being informed why requested forms of treatment are not made available, refusing specific forms of treatment that are offered, and being informed of prognosis.
14. A client has the right to review their treatment file with a staff member, at a reasonable time.
15. A client has the right to be informed by the prescribing physician of the name, purpose and possible side effects of any medication prescribed as part of their treatment.
16. A client has the right to request a written summary of treatment at time of discharge: that summary must include discharge and transition plans.
17. A client has the right for all of their information to be maintained confidentially and the right to give prior written approval for the release of identifiable information.

Except for clients in State of Alaska Department of Corrections (DOC) programs, as per DOC regulations, policies, and procedures.

If you believe your rights have been violated, please contact:

- YOUR Akeela Counselor / Clinician, Program Manager or Director.
- You can always call Akeela's Compliance Hotline at 907-565-1200.
- You can also contact the Alaska Division of Behavioral Health, The Disability Law Center, or other organizations of your choosing.



**ACKNOWLEDGEMENT OF
CLIENT RIGHTS and NOTICE of PRIVACY PRACTICES**

The undersigned person acknowledges receiving a copy of Akeela Inc. “Client Rights” and “Notice of Privacy Practices” and has had the opportunity to have my questions answered. The signature below signifies my receipt.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE

AKEELA STAFF SIGNATURE	DATE



TELE-BEHAVORIAL HEALTH CONSENT FORM

I, _____(name of client) hereby consent to receiving tele-behavioral health services from Akeela, Inc. (“Akeela”). I understand that tele-behavioral health is the provision of professional counseling services via a virtual delivery system, such as audio/video synchronous technology. The tele-behavioral health services will be provided through an internet-based platform and data is encrypted for high levels of protection and privacy. Tele-behavioral health services are provided by Akeela clinical staff and licensed professionals contracted by Akeela. Tele-behavioral health services may include evaluation, assessment, consultation, treatment and psychoeducation. Akeela clinical staff and licensed professionals contracted by Akeela who are trained in the use of tele-behavioral health will provide all tele-behavioral health services.

Technology: I understand that in order to receive tele-behavioral health services I must have reliable internet and a laptop, desktop, or tablet with a microphone and video. I may need to download an application and/or software to use participate in tele-behavioral health services. I understand and acknowledge that I will need access to, and familiarity with, the appropriate technology in order to participate in tele-behavioral health services. I further agree to comply with the Terms of Use and Privacy Policies of the technology platform utilized in my tele-behavioral health encounters.

Crisis/Emergency Policy: Tele-behavioral health sessions are considered outpatient services and are not a substitute for emergency or crisis services. I understand and acknowledge that an Akeela clinical staff member or licensed professional contracted by Akeela may not be available for contact between scheduled sessions. In the event of a crisis or mental health emergency, I understand that I should use my local crisis line, dial 911, or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand it is my responsibility to ensure my contact information and emergency contact information are kept up-to-date with Akeela.

Continuity of Care: Akeela will require a release of information before sharing my personal health information with my primary care physician, pediatrician, and any additional behavioral health providers or other outside agencies.

Confidentiality: I understand that the information disclosed by me during the course of my teletherapy services is confidential. However, there are mandatory and permissive exceptions to confidentiality including, but not limited to: (i) suspected child, elder, and/or dependent adult abuse; (ii) expressed threat of violence towards an ascertainable victim; (iii) expressed threat to harm or kill self; and (iv) court order / subpoena. I recognize that transmissions over the internet are at my own risk and that Akeela cannot guarantee the security of any information I transmit to them over the internet.

Rights and Obligations with Respect to Tele-Behavioral Health:

1. I have the right to withdraw my consent for tele-behavioral health services at any time without affecting my right to future care or treatment upon written notice to my Akeela treatment team.
2. I understand that Akeela has the right to discontinue services at any time upon written notice to me.
3. I acknowledge that no guarantee has been made to me regarding the effectiveness or result of evaluation and/or treatment.
4. I understand that I will need to provide Akeela with an emergency contact in case an emergency should occur while I am receiving services from Akeela.
5. I understand that tele-behavioral health services may not be as complete as in-person services. I also understand that if my Akeela treatment team believes that I would be better served by in-person services, arrangements will be made to begin in-person services, if available. If in-person services at Akeela are not available, I will be referred to another agency who can provide such services in my geographic area.
6. I understand the above-stated description of tele-behavioral health and consent to receive services through an internet- based platform. I will make every effort to maintain the security and privacy of my sessions. I release all Akeela professionals and entities from any liability should privacy or security be breached due to my failure to provide a private and secure session.
7. In the event that the client is a minor, I acknowledge and agree that a parent or legal guardian must be present during tele-behavioral health session(s).
8. This contract will be governed by the laws of the state in which I reside.
9. I understand it is my responsibility to notify my Akeela treatment team if I am receiving services in a state other than where I reside.
10. I understand that there are benefits, risks, and possible consequences associated with tele-behavioral health services, including, but not limited to, the possibility, despite reasonable efforts on the part of Akeela, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my treatment information could be accessed by unauthorized persons.
11. I understand that I have a right to access my treatment information and to obtain copies of treatment records in accordance with federal and state law.

I have read and understand the information provided above. I understand the risks, benefits and my rights related to tele- behavioral health services. I have discussed the information with my Akeela treatment team and all of my questions have been answered to my satisfaction. My signature below indicates that I hereby request and give my informed consent to Akeela’s provision of tele-behavioral health services.

CLIENT SIGNATURE	DATE
CLIENT ADDRESS (Street, City, State, Zip Code)	CLIENT’S PRIMARY PHONE NUMBER



CLIENT MEDICAL RELEASE/EMERGENCY CONTACT INFORMATION

For your Safety, the following information will be kept in a secure area, accessible only to staff members, while you are attending treatment at Akeela. All information must be current in case of an emergency. Please complete the following:

I _____ hereby give my consent to be given emergency medical treatment in the event of an accident, injury, or illness. I hereby release the Akeela and its representatives from any liability rising from an emergency in which it is deemed necessary to pursue medical treatment.

In case of an emergency Akeela may contact:

NAME	RELATIONSHIP	CONTACT PHONE NUMBER
1.		
2.		

List any of your medical information that would be important during an emergency.

DRUG/ALLERGIES	
MEDICATIONS	
OTHER MEDICAL CONDITIONS	

Is there an Advance Directive in place? YES NO

If Advance Directive obtain copy and place in chart and give to emergency personnel.

By signing below, I authorize the above information to appropriate medical personnel.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE

AKEELA STAFF SIGNATURE	DATE



AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____ PHONE #: _____ hereby request/authorize records be sent:

TO/FROM: _____
 Name of Person/Agency Address City, State, Zip Code

TO/FROM: AKEELA, INC 360 West Benson Blvd Anchorage, Alaska 99503
 Name of Person/Agency Address City, State, Zip Code

How Records/Information are to be delivered (INITIAL all that apply):

<input type="checkbox"/>	FAX: (Number)	<input type="checkbox"/>	ELECTRONIC (EMAIL)*:	<input type="checkbox"/>	VERBAL	<input type="checkbox"/>	MAIL	<input type="checkbox"/>	I will pick-up records	<input type="checkbox"/>	Exchange Information between parties
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*Email is not considered to be as secure as other means of delivery and should be carefully considered prior to authorization.

For care received from: _____ to _____
(MM/YY) (MM/YY)

Type of Records/Information to be delivered (INITIAL all that apply):

<input type="checkbox"/>	Admission Assessment	<input type="checkbox"/>	Transfer/Discharge Summary	<input type="checkbox"/>	Progress Notes	
<input type="checkbox"/>	Treatment Plan/Updates	<input type="checkbox"/>	Attendance	<input type="checkbox"/>		Leave Message for client to contact agency
<input type="checkbox"/>	UA Results	<input type="checkbox"/>	Client Presence in Treatment			
<input type="checkbox"/>	Other(Please specify):					

The purpose of the release of this information is (INITIAL all that apply):

<input type="checkbox"/>	Sharing with other health care providers	<input type="checkbox"/>	My personal records	<input type="checkbox"/>	Legal
<input type="checkbox"/>	Coordination of Care	<input type="checkbox"/>	Further Treatment		
<input type="checkbox"/>	Other(Please specify):				

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that the individuals(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken reliance on it and that in any event this consent expires automatically as follows: **(Date of expiration or Event triggering expiration)** _____; **if no date/event is specified, this consent will expire one (1) year from date of signature.**

By my signature below I indicate that I have read this document, or have had it read to me, that I fully understand its meaning, that I have consented to its terms knowingly and voluntarily, that I have not been under any undue duress or influence of alcohol or drugs in making this agreement.

Signature of Client Date

Signature of Parent, Guardian, or person authorized Date

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

REVOCAION: I, _____ hereby revoke the above Release of information as of: _____ (date).

Signature of Client Date

Signature of Parent, Guardian, or person authorized Date