AKEELA

BEHAVIORAL HEALTH TREATMENT REGISTRATION FORMS

Please Select ALL Akeela Service(s) of Interest:

☐ Assessment Center
☐ Outpatient – Mental Health
☐ Residential – Akeela House
☐ Psychiatric Evaluation
☐ ADIS
☐ Outpatient – Substance Use
☐ Residential – Stepping Stones
☐ 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? ☐ YES ☐ NO
SECONDARY PHONE NUMBER	**( )**
	We can leave a message on secondary phone? ☐ YES ☐ NO
EMAIL ADDRESS	
	It is OK to receive email at the address above? ☐ YES ☐ NO
SOCIAL SECURITY NUMBER	

DEMOGRAPHICS

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

AKEELA

PAYER INFORMATION	
PRIMARY PAYER/INSURANCE	**SECONDARY PAYER/INSURANCE**
☐ AK Medicaid ☐ None/Self Pay ☐ Sliding Scale/Income Based ☐ Other - If other, specify	☐ I Have a Secondary Payer/Insurance Name of 2nd Insurance Provider: ☐ 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)	☐ YES Your Due Date: ☐ NO ☐ Does not Apply
Have you ever injected drugs? (select one)	☐ YES Date of Last Use: ☐ NO
Do you use tobacco products? (select one)	☐ YES If YES, select type ☐ NO ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Pipe ☐ Smokeless
Are you participating in Opioid Replacement Therapy? (select one)	☐ YES Agency/Provider Name: ☐ NO

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

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

AKEELA

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**

AKEELA

TREATMENT PROGRAMS FINANCIAL INFORMATION AND RELEASE

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 ☐ YES ☐ 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 CRF 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.

Client or Personal Representative Signature	**Date**

Printed Name of Personal Representative	**Description of Personal Representative's Authority**

Akeela Staff Signature	**Date**

REVOCATION 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).

Client or Personal Representative Signature	**Date**

Printed Name of Personal Representative	**Description of Personal Representative's Authority**

AKEELA

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

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:

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

AKEELA

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.

AKEELA

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-BEHAVIORAL 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**

CONSENT FOR TREATMENT AND PROGRAM AGREEMENT

SECTION I: GENERAL

PLEASE INITIAL EACH CLAUSE INDICATING YOUR AGREEMENT:

_____ I hereby consent to treatment at Akeela. This authorization and consent are given in recognition that I have been informed of and agree to comply with all rules and conditions while I am a client in the Akeela Inc., behavioral health treatment program. My agreement is indicated by my signature and by my written initials placed next to each item.

_____ I understand that my consent for behavioral health treatment services is voluntary and may be withdrawn at any time. I further understand that any changes in my assessment and/or treatment will be discussed with me prior to such changes becoming effective and will be subject to my approval.

_____ If enrolled in a substance use treatment program, I agree to remain abstinent from the use of any mood-altering chemicals (including alcohol or marijuana) other than those prescribed for me by licensed medical professionals during the course of treatment. I further agree to participate in random urinalysis testing. Upon request by program staff, I will provide a sample of my urine for testing/analysis.

_____ I acknowledge and understand that no promise or guarantees have been made to me regarding the outcome of my treatment by Akeela and do hereby absolve Akeela from liability in the event my treatment is unsuccessful.

_____ I have been advised that while I participate in Akeela I will be responsible for all medical bills I incur because of injuries and/or accidents that occur while I am involved in social, sport, or other activities. I further understand that Akeela does not mandate my participation in social and/or sport activities. I will not hold Akeela or its staff responsible for any injury unless negligence is involved.

_____ I hereby authorize Akeela to contact me by mail, telephone or in person after my discharge or graduation as follow-up is an integral part of my overall treatment.

_____ I have received separate documents regarding Client Rights and Akeela's Notice of Privacy Practices and have had an opportunity to receive an explanation and ask questions regarding them. I understand I may acquire information regarding other clients which must be kept confidential and that there are legal penalties (fines and prison sentences possible) for the unauthorized disclosure of this information.

SECTION II: ATTENDANCE

_____ I agree to be on time for all assigned scheduled group or individual counseling sessions. I understand that if I am late, I may not be admitted to the group session

_____ Subject to ongoing assessment and evaluation of my treatment progress, I may expect changes in the level and duration of services while I am enrolled. Further, I may expect these changes to be discussed by the treatment team and any modifications will be in the best interest of my treatment.

_____ My attendance at other support groups such as Alcoholics Anonymous, Narcotics Anonymous, Adult Children of Alcoholics, NAMI, Peer Support Network, etc. may be required of me as determined by the treatment team.

SECTION III: TREATMENT CHARGES

_____ I agree to pay the cost of my treatment. I will make arrangements with the Financial Office before starting my treatment program.

_____ I acknowledge that all fees for services are due to and payable at the time of the service unless other arrangements have been made for me.

Section IV: CLIENT GRIEVANCE PROCEDURES

All clients have the right to file a formal grievance if they believe that their civil and /or human rights have been violated by Akeela. A staff person of Akeela will help any client file a formal grievance and assist the client in the procedures. All formal grievances must be filed in writing.

Procedures for Filing a Formal Grievance

1. Any client who believes that his or her civil and/or human rights have been violated will first discuss the incident with the Akeela employee(s) involved.
2. This meeting will take place within two (2) working days of the incident.
3. Another person will be selected by both parties to be present at this meeting. This person will act as a mediator.
4. This meeting will take place in private and remain confidential.
5. All attempts to resolve the grievance will be made during this meeting.

Written Grievance

If the grievance cannot be resolved in this meeting, the client may file the complaint in a written statement to the Clinical Director or designee. This written statement must be filed within five (5) days following the initial meeting. If the complaint involves the Clinical Director, the Executive Director will designate an impartial staff member to conduct the meeting.

The Clinical Director or designee shall meet with the client no later than five (5) days after receiving the written statement. During this meeting, the Clinical Director or designee will meet to resolve the grievance with the client. If the grievance is resolved during this meeting, no further action will be taken, but a written record of the meeting and outcome will be filed in the client's file and in an Administrative Grievance File.

Written Grievance to the Executive Director

If the client believes that the complaint has not yet been resolved, a written grievance may then be filed with the Executive Director or designee. This grievance must be filed within five (5) working days after the meeting with the Clinical Director or designed alternate.

The Executive Director or designee will inform the client both verbally and in writing of a final decision. The client will be informed of this decision within five (5) working days from the date of filing the complaint with the Executive Director. If a decision is not reached by the Executive Director or designee within this time frame, the client will be told the reason for the delay and a revised, mutually agreeable time will be adopted. However, the Executive Director or designee must make the final decision within thirty (30) days.

Appeal

The client may at any time notify the Division of Behavioral Health or the Joint Commission of the complaint. The client will be informed verbally and in writing of the results of the grievance procedures. Copies of the procedure's findings may be provided to any employee involved in the grievance proceedings. No client filing a grievance will be given punishment or harassment. Grievance procedure time limits may be extended by mutual consent between the client and Akeela Treatment Services. A full explanation of the policy and procedures for filing a grievance will be explained to the client before the formal procedures begin.

Client Statement

My signature below indicates that I have read and have had the opportunity to discuss and ask questions about the foregoing "CONSENT FOR TREATMENT AND PROGRAM AGREEMENT"; that I fully understand the meaning of each point; that I knowingly **and voluntarily consent** to the terms of each one; and that I have not been under any duress or force nor under the influence of alcohol or other drugs.

CLIENT SIGNATURE	DATE

Witness Statement

My signature below indicates that I have witnessed and now certify the validity and legitimacy of the above Client's signature.

WITNESS SIGNATURE	DATE

AKEELA

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):

	FAX: (Number)		ELECTRONIC (EMAIL)*:		VERBAL		MAIL		I will pick-up records		Exchange Information between parties

*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):

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

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

	Sharing with other health care providers		My personal records		Legal
	Coordination of Care		Further Treatment		
	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

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

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian, or person authorized Date