CLOUD PEAK COUNSELING CENTER
401 South 23rd Street, Worland, WY 82401
Phone (307) 347-6165 Fax (307) 347-6166
www.cloudpeakcc.org

APPLICATION FOR SERVICES

Welcome to Cloud Peak Counseling Center (CPCC). Our agency exists for the benefit of the public and is staffed by well-trained professionals. We offer a variety of services and will do our best to provide the services you require. All information is confidential.

Today's Date: _____

CLIENT INFORMATION

Client Name: First_____ M.I.____ Last_____ Maiden Name :_____

Date of Birth: _____ Age: _____ Social Security Number: _____ Gender: _____

Place of Birth: _____ Mother's First Name: _____

Residence Address: _____ Apt #_____

City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Message Phone: _____

Employer:_____ Employer/Work Phone_____

Email:_____ May we contact you/ leave a message at: Home? Yes / No Mobile? Yes / No Work? Yes / No

May we send correspondence to your mailing address? Yes / No If no, what is your alternative:_____

Spouse's Name: First_____M.I.____Last_____Spouse's Date of Birth:_____

Spouse's Social Security Number:_____ Spouse's Employer:_____

In Case of Emergency Contact: _____Relationship:_____Phone:_____

Address: _____City: _____ State: _____ Zip:_____

How would you prefer to get reminder notifications for your appointments? Phone: ____ Text: _____ Email: _____

DEMOGRAPHICS

RACE:
___ Caucasian
___ African American
___ Native American/ Alaskan
___ Asian
___ Other/ Unknown
___ Native Hawaiian/ Other Pacific Islander
___ More than One Race

HISPANIC ORIGIN:
___ Not Hispanic
___ Cuban
___ Puerto Rican
___ Mexican
___ Other Hispanic
___ Unknown

Name of School_____
Highest Grade Completed: _____

VETERAN STATUS: Y / N
Combat: Y / N
Non-combat: Y / N

EMPLOYMENT STATUS:
___ Unemployed
___ Part-Time
___ Full-Time
___ Homemaker
___ Retired
___ Disabled
___ Child Under 15
___ Student Over 15
___ Inmate of Institution

MARITAL STATUS
___ Never Married
___ Now Married
___ Separated
___ Divorced
___ Widowed
___ Minor Child

Do you have an Advance Directive or Living Will? Yes / No

BILLING INFORMATION

How do you plan to pay for services?

___ Self Pay: *Person Responsible for Payment* _____

___ Equality Care (Medicaid): *Equality Care Number* _____

___ Kid Care CHIP: *Kid Care Number* _____

___ Department of Family Services: *Name of Caseworker* _____

Phone of Caseworker _____

___ Department of Vocational Rehabilitation *DVR Case Number* _____

___ Other Contract: *Agency Name* _____ *Contact Person* _____

Address _____ *Phone* _____

___ Veteran Affairs

___ EAP: *Employer* _____ *Phone* _____

Authorization Number _____ *How many sessions?* _____

___ Health Insurance (Please fill out the following information)

PRIMARY INSURANCE

Policy Holder Information:

Name of Policy Holder: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Phone: _____

Name of Insurance Company: _____ Phone: _____

Identification Number: _____ Group Number: _____ Relationship to Client: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

For Questions About Billing Please Contact:

Kacey Pedersen/Billing Clerk
Mary Johnson/Corporate Compliance Officer
(307) 347-6165
(307) 347-6166 Fax

Have you considered whether or not you are eligible for Equality Care/ Kid Care CHIP health benefits? If you are interested in the eligibility requirements or would like to apply for these benefits please ask our front office staff for an application. Completed applications must be returned to Department of Family Services (DFS) for a final determination.

FINANCIAL AGREEMENT

Name: _____ Social Security Number: _____

1. Cloud Peak Counseling Center (CPCC) is a private, non-profit organization, established to help people with emotional and/or behavioral problems and to provide consultation and education to community organizations. CPCC receives some public funding, but that funding provides only a part of the financial support needed to operate CPCC. The balance must come from the individuals who receive services. Fees for services are assessed on an "ability to pay" basis, as shown on the Fee Schedule.

2. If you have health insurance, we will bill your insurance company CPCC's full provision of services rate. The current rates of service are posted. However, the client is always responsible for payment for services assessed at his or her adjusted income rate, unless the adjusted income rate plus the insurance payment exceeds current rates. In that case, the client is responsible only for the difference between the insurance payment rate and CPCC's full provision of services rate.

3. If you have Equality Care (Medicaid), we will bill the charges directly to Equality Care for services covered. If you receive services from CPCC not covered by Medicaid, you will be charged according to your adjusted income rate.

4. A No-Show Fee will be charged if you fail to show up for a scheduled appointment. The No-Show Fee is flat $10.00 rate it the client does not show to an appointment. This is applicable for all services excluding medication management or medication-telehealth appointments. Medication management/telehealth no-show appointments will be assessed a $25.00 fee. The client has up until the time of the appointment to cancel, anything after the appointment time will be assessed as a no-show. The no-show fee is due at the time of the next service. The client is responsible for re-scheduling an appointment following a no-show. Appointments will not be re-scheduled during the same week. All no-show fees will be at the discretion of the therapist with supervisor approval.

5. **The recipient of services is required to make full payment at the time services are provided, unless other arrangements have been made with the business office in advance. All statements of account are due and payable in full upon receipt.**

6. I understand and agree that I am responsible to pay for all services provided to me by Cloud Peak Counseling Center and its staff. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all attorney fees-should legal action need to be taken.

FEE SCHEDULE

Gross Annual Family Income $_____. Number of dependent persons in family _____ x $4,720 deductions _____

Adjusted Gross Income $_____.

ADJUSTED INCOME	PERCENT OF FULL FEE
At or Below 100% FPL	$10.00 Flat Rate
$13,590 - $19,999	10%
$20,000 - $29,999	20%
$30,000 - $39,999	30%
$40,000 - $49,999	40%
$50,000 - $59,999	50%
$60,000 - $69,999	60%
$70,000 - $79,000	70%
$80,000 - $89,000	80%
$90,000 - $99,999	90%
$100.000 and Above	100%

2022 Poverty Guidelines

Persons in family/household	Poverty guideline
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630

For each additional person, add $4,720

Your adjusted income rate is _____ percent of the full fee. Charges for other services, such as books, testing materials and fees, evaluations, and some workshops or classes may not be adjusted to our sliding fee scale. If you believe that the fee set by the sliding scale is unreasonably inconvenient, discuss this with your therapist or the business office.

If your financial or insurance situation changes while you are receiving services, it is your responsibility to report your new status to CPCC.

CHECK APPROPRIATE BOX:

( ) I hereby state that I do have third party coverage with _____ and that I will provide CPCC with all appropriate claim forms in order for direct payment to be made to CPCC. I authorize release of information necessary to process claims and authorize direct payment of benefits to CPCC. If payment is made directly to me, I hereby agree to promptly remit such payments to CPCC. I understand that I will be responsible for payment for any services not covered by my insurance.

( ) I hereby state that I do have third party coverage, but I do NOT want CPCC to bill my third party insurance. I understand, with this decision, I will be billed at the full fee.

( ) I hereby state that I do NOT have third party coverage. If I obtain such coverage in the future, I will immediately notify CPCC.

I acknowledge that I have read and understand the foregoing Financial Agreement and agree to abide by all of its terms and conditions.

_____ _____

Signature of client OR parent, guardian or person authorized to sign for client. Date

Relationship to client_____

Witness Date

Mental Health and Substance Abuse Division

In an effort to continually improve Wyoming treatment programs, we ask that you please read and sign the following form. By your signature, you are consenting to provide your Social Security Number for the purposes and under all the protections set forth in applicable state and federal laws. According to W.S. 9-2-125, records shall remain confidential except as required by law. You may revoke this at any time by signing and dating the revocation section of this form and returning it to the office.

- In order to improve treatment programs it is necessary for the State of Wyoming to conduct research, to audit programs and payments for services and to monitor treatment outcomes.
- By signing this form you are consenting to voluntarily disclose your Social Security Number (SSN) to the Wyoming Department of Health (WDH). Once received by the WDH, your SSN is kept Safe by using electronic encryption to alter your nine-digit SSN into a 25-digit number that will make is impossible to identify.
- The Department of Health is required by state and federal laws and regulations to protect your Social Security Number and all other personal health information obtained from you. If we fail to do so, there are penalties of law and you may be entitled to bring a law suit against the Department. In order to comply with these laws, the Department has implemented policies and procedures to protect your information from unlawful uses.

Please read the following statements prior to signing the document:

- I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties only in accordance with state and federal laws that will continue to protect your information.
- I understand this authorization will not expire pursuant to 45CFR 164.508(c) (v).
- Under the Privacy Act of 1974, I understand that my disclosure of this information to the Wyoming Department of Health is Voluntary, that the Department of Health has the authority to collect and maintain this information (pursuant to W.S. 9-2-125 et seq.) and that the uses of this information will include:
    - Research to include the creation and maintenance of research database and research repository pursuant to 45CFR Part 2, sec. 2.31 et seq., W.S.35-2-607 et seq., W.S. 9-2-126 et seq., and
    - To determine compliance with state and federal reporting requirements, management of financial audits, and programs monitoring and evaluation.
- I understand all information will be kept strictly confidential and database security will include encryption which meets or exceeds the highest.
- I understand my eligibility for treatment is not dependent on my signature and that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
- I understand I will be provided with an updated version of the WDH notice of privacy practice every three years.

I hereby authorize the use/disclosure/use and disclosure of my Social Security Number (please print):

Client Name:	SSN:
Address:	Date of Birth:
Witness:	Date:

I hereby authorize the following program to receive these disclosures:
Authorized program: Wyoming Department of Health, Mental Health and Substance Abuse Division
Research/Data Manager, 6101 Yellowstone Ave, Suite 220 Cheyenne, WY 82002 Telephone: (307) 777-7903

Client Signature: _____ Date: _____

Thank you for agreeing to help us improve services in Wyoming!

Complete this section ONLY if the form is not signed by the client him/herself

If not signed by the client please indicate the relationship:

__ Guardian or conservator of an incompetent client
__ Parent or guardian of minor client
__ Beneficiary or personal representative of deceased client
__ Other (specify) _____

Name of Client: _____

For Office use only: Documentation or Relationship: __ Reviewed __ Attached

Complete this section only if the client has chosen to revoke their prior authorization for release of private health information

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Wyoming Department of Health program listed above. I further understand that such revocation does not apply to persons which have already acted in reliance on the authorization.

I hereby Revoke this authorization: _____ Date: _____

Cloud Peak Counseling Center

ACKNLOWLEDGEMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES & CLIENT HANDBOOK

By my signature, I acknowledge that I was given a copy of the Notice of Privacy Practices & Client Handbook of Cloud Peak Counseling Center. I understand the following information:

- Ways in which Cloud Peak Counseling Center will use my personal health information
- Client rights and responsibilities
- Grievance and appeal process
- Evaluation methods
- Services and activities
- Expectations
- Hours of operation
- Access to after hour care
- Code of ethics
- Confidentiality policy
- Requirements for follow up
- Financial obligation
- Process of clinical assessment, treatment plan, coordination of care, the referral and discharge planning
- Map of CPCC

Client's Signature: _____

Client's Printed Name: _____

Date of Receipt of Notice & Handbook: _____

Initials of Center representative confirming this acknowledgement: _____

Date: _____

THIS ACKNOWLEDGEMENT WILL BE KEPT AS PART OF CLIENT'S RECORD AS REQUIRED BY THE HIPAA PRIVACY RULE.

Revised 04/21

CLOUD PEAK COUNSELING CENTER

CLIENT HANDBOOK

NATIONAL ACCREDITATION

CPCC's outpatient treatment services for children, adolescents and adults have been accredited by CARF (Commission on Accreditation of Rehabilitation Facilities). CARF is an independent, non-profit accrediting agency that establishes consumer-focused standards for health care organizations. To receive accreditation, an organization must meet their quality standards and demonstrate its commitment to consumer satisfaction.

Hours of Operation – Cloud Peak Counseling Center is open from 8:00am – 6:00pm Monday thru Friday.

Smoking Policy – Cloud Peak Counseling Center offers a smoke-free environment to all staff and clients. No smoking is allowed in company vehicles or inside the buildings, with the exception of designated areas in the Hope House.

Drug and Alcohol Policy – Possession, use, sale, purchase, or distribution on Agency property of any alcohol, illegal drugs, or illegally possessed drugs is strictly prohibited.

Firearms/Weapons Policy – Firearms or weapons are not permitted in company vehicles or on any agency property, including all facilities and parking lots.

Seclusion and Restraint Policy - Under no circumstances is physical punishment ever to be administered to persons served. Cloud Peak Counseling Center does not use seclusion or restraint as a means to manage client behavior.

Safety Policy - All Agency sites will comply with generally accepted standards governing health, sanitation, fire safety and with existing local inspection codes. Exits are clearly marked in each facility as well as fire alarms and extinguishers. Clients should report any safety concerns to their primary therapist, or the Agency's Corporate Compliance Officer. Clients may complete a Critical Incident form which they can obtain from their therapist or support staff.

Communicable Diseases – Clients are encouraged to access communicable disease screenings at Public Health, 1007 Robertson, Worland, WY Phone 347-3278.

HOW YOU RECEIVE SERVICES

Below is the step by step process by which you will receive services through CPCC. These steps are not all inclusive, and depending on your needs, may change in an effort to best provide you with successful outcomes. We believe that you need to be involved in the process of determining your treatment and the method(s) by which your needs are met.

Initial Contact with CPCC – When you contact CPCC for services you will be asked questions regarding demographic information (name, address, phone, etc), the presenting problem/issue, who referred you, and financial information. An appointment will be made for you and you will be asked to arrive at the center 30 minutes prior to your scheduled appointment to complete the intake paperwork. (If you are experiencing an emergency where you are at risk of harming yourself or others, you will be seen when you contact our office.)

Intake/Orientation – You will meet with your primary therapist and review/complete the necessary paperwork needed to open your medical record and begin assessment of the mental health issues and best course of treatment. You will be provided with information regarding services at CPCC (such as the Client Handbook) so that you are prepared to participate in both your assessment and treatment planning.

Clinical Assessment - Your strengths, weaknesses, and needs are further identified.

Treatment Planning – You and your therapist determine a plan of treatment based on the assessed issues and needs. The treatment plan will include goals and objectives/timelines for achieving these goals. It will also include the methods and frequency of services and who will be involved in the delivery of services. You and your therapist will update this treatment plan every 90 days.

Outpatient therapy –You and your therapist will confer on the dates and times of sessions, and type(s) of sessions (individual, family, couples, and/or group).

Case Management – The use of resources and other staff, as necessary, to assist you in achieving your treatment goals. This may include assistance in locating housing, job hunting, financial management, and a variety of other types of assistance.

Crisis Intervention – CPCC therapists are requested by local physicians, hospital emergency room staff and law enforcement officers to intervene in crisis situations. If you are at risk of harming yourself and/or others, you may access emergency services 24 hours a day, 7 days a week by calling 347-6165.

Psychiatric Services/Medication Management – If you are in need of medication, you may be referred to the agency's medication management provider. To qualify to receive CPCC's medication management services, you must be a client, have completed the intake and clinical assessment process, and are seeing a therapist on a regular basis.

Client Education – Providing information to you, your family, or others upon your request, regarding your mental health issue. This can occur from intake throughout treatment.

Referral – At times it may be necessary to work with other community resources to assist you in meeting your needs. We will make appropriate referrals to these resources, and it will be your responsibility to follow through on these referrals.

Report and Record Keeping – All information related to your assessment and treatment will be charted in your record.

Consultation with other Professionals – All CPCC staff involved in your care may be consulted regarding your treatment. If consultation with outside agencies is necessary, it will occur only after you sign a release of information, except in those circumstances as outlined in the Notice of Privacy Practice.

Discharge/Transition Plan – When treatment goals and objectives have been met, you and your therapist will complete a discharge process which will include a transition plan for aftercare and follow-up.

Follow-up – Following your discharge from treatment, CPCC will contact you at some point to conduct a follow-up survey regarding your progress since discharge.

Cloud Peak Counseling Center
Mental Health Program

Cloud Peak Counseling Center is a non-profit organization governed by a Board of Directors and is certified as Mental Health and Substance Abuse Providers by the Wyoming Department of Health and CARF accredited.

Seeking appropriate help when you need it is a sign of strength. Our professionals are here to consult with you or your family. CPCC fees are adjusted according to ability to pay. No one is denied services because of an inability to pay.

Our Mission

To provide quality mental heath and substance abuse treatment and prevention services to the citizens of Washakie County and the Big Horn Basin.

Our Philosophy

To improve the quality of life to the persons served by offering guidance in the following areas:

- Life Stressors
- Acute or Chronic Mental Illness
- Relationship Issues
- Vocational Adjustment
- Utilizing Community Resources
- Recovery Services

Services

CPCC has therapists who specialize in different areas of Mental Health counseling. Staff can help families or individuals with their situations through:

- Individual Counseling
- Couples/Family Counseling
- Group Counseling
- Clinical Assessment
- Specialized Treatment for Trauma
- Case Management
- Psychiatric Services
- Outreach
- Consultation and Education
- Psychological Evaluations
- Supported Employment & Housing
- Emergency Services (24 Hr)
- Lighthouse (Acute Psychiatric Beds)

Individual/Couples/Family Counseling

Therapist contact with clients and collaterals as necessary for the purpose of developing and implementing the treatment plan for the client.

Group Counseling

Therapist contact with two or more unrelated clients and collaterals as necessary for the purpose of implementing each client's treatment plan.

Clinical Assessment

Therapist contact with clients and collaterals as necessary for the purposes of completing an evaluation of the client's mental health disorders and treatment needs.

Specialized Treatment for Trauma

Specialized psychological and therapeutic services (i.e. EMDR) effective in treating clients with trauma.

Case Management

Individual service used to assist individuals in gaining access to needed medical, social, educational and other services.

Psychiatric/Medication Management Services

Prescription of and/or monitoring of the effects of psychotropic medications.

Outreach

Face-to-face or telephone contact with a person who would otherwise not seek services or their family members for the purpose of screening for service need and/or engaging in the potential client in mental health treatment.

Consultation and Education

Consultation services are case-centered or program-centered services rendered to other human service agencies, health care professionals, or human service oriented groups in order to assist them in meeting the mental health needs of their constituents who are not clients. Education services are designed to increase the level of mental health knowledge or skills of the lay public or specialized groups of individuals.

Psychological Evaluations

A Psychologists evaluation of the client's mental health disorders and treatment needs.

Supported Employment & Housing

Provide supportive independent living for individuals with a (SPMI) serious and persistent mental illness. Services are tailored to optimize ones social, personal, and vocational competency in order to live successfully in a community setting.

Emergency Services

Emergency services are provided for residents of Washakie County. An on-call therapist is available 24/7. CPCC works with local physicians, hospital emergency room staff and law enforcement officers to intervene in crisis situations.

Lighthouse (Acute Psychiatric Beds)

The Lighthouse stabilization program is a 24/7 residential program for a limited duration to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the needs of the persons served. Lighthouse serves the Big Horn Basin Region.

CPCC will address the special needs of persons seeking services.

Cloud Peak Counseling Center
Substance Abuse Program

Cloud Peak Counseling Center is a non-profit organization governed by a Board of Directors and is certified as Mental Health and Substance Abuse Providers by the Wyoming Department of Health and CARF accredited. CPCC fees are adjusted according to ability to pay. No one is denied services because of an inability to pay.

Our Mission

To provide quality mental heath and substance abuse treatment and prevention services to the citizens of Washakie County and the Big Horn Basin.

Philosophy

To improve the quality of life to the persons served by offering guidance in the following areas:

- **Life Stressors**
- **Acute or Chronic Mental Illness**
- **Relationship Issues**
- **Vocational Adjustment**
- **Utilizing Community Resources**
- **Recovery Services**

Our Goal

To reduce or eliminate life problems related to substance misuse.

Services

CPCC therapists who are licensed and trained in substance abuse are available for Substance Abuse counseling. Staff can help families or individuals with their substance abuse problems with the following services:

Intensive Outpatient Treatment (IOT)

IOT is a nine hour per week program. Eight hours of group and one hour of individual counseling. The length of the program is based on individual needs and progress through the program. Goals and needs are determined through assessment and an individualized treatment plan. CPCC IOT programs serves Washakie, Hot Springs and Southern Big Horn Counties.

Program components include:

- Understanding addiction & addictive behaviors
- Medical aspects
- Group counseling
- Individual counseling
- Medication information
- Nutrition & fitness
- Community support & recovery groups
- Linkages to educational/vocational activities
- Relapse prevention
- Co-occurring disorders (SA and mental disorders)

Participants remain in the community with their families and can continue to work during treatment.

IV drug users and pregnant women take precedence.

Aftercare

This is an ongoing group meeting for an hour and a half per week. This is a sobriety and recovery maintenance group focusing on relapse prevention and other issues relevant to recovering individuals.

Individual Counseling Service

This service is designed to address less severe or specific issues which might be effectively treated in a one on one setting. Persons with issues of chemical abuse or early stage dependency might be appropriately treated at this level of service. Family members or significant others would also be appropriate for this service. The primary intervention for problems with chemical dependency still takes place in group counseling.

Couples Counseling

This service is primarily designed to examine relational problems inherent in relationships involving chemical dependency. It offers couples an opportunity to understand the relationship between life problems and chemical use. Problems can be identified along with goals, solutions and healing strategies.

Family Counseling

This service is designed for family members of chemically dependent individuals. Family members learn about chemical dependency and its effects on them as individuals and the family system. They learn how to reduce and cope more effectively with stresses created by the chemically dependent family system.

Substance Use Evaluations

This service is designed to ascertain whether or not an individual has a substance abuse or dependence problem. The severity of the disorder will determine what treatment recommendation is appropriate if any.
Procedures:

- Clinical interview
- Diagnostic instruments-ASI-ASAM-SASSI

Case Management

This service is used to assist individuals in gaining access to needed, medical, social, educational and other services.

Consultation and Education

This is a case-centered or program centered service rendered to other human service agencies, health care professionals or human service oriented groups in order to assist them in meeting the substance abuse needs of their constituents who are not clients of CPCC. Education services are designed to increase the level of substance abuse knowledge or skills of lay public or specialized groups of individuals in the community.

Emergency Services

Emergency services are provided for residents of Washakie County. An on-call therapist is available 24/7. CPCC works with local physicians, hospital emergency room staff and law enforcement officers to intervene in crisis situations.

CPCC will address the special needs of persons seeking services.

Cloud Peak Counseling Center
Child and Adolescent Program

Cloud Peak Counseling Center is a non-profit organization governed by a Board of Directors and is certified as Mental Health and Substance Abuse Providers by the Wyoming Department of Health and CARF accredited. CPCC fees are adjusted according to ability to pay. No one is denied services because of an inability to pay or involvement in the juvenile justice system. Kid Care and Medicaid are both accepted.

Our Mission

To provide quality mental heath and substance abuse treatment and prevention services to Washakie County.

Our Philosophy

To improve the quality of life to the persons served by offering guidance in the following areas:

- Adjustment Issues
- Acute or Chronic Mental Illness
- Peer/Family Relationship Issues
- School Issues
- Behavior Problems

Services

CPCC therapists who specialize in child and adolescent counseling and trained in substance abuse are available for Child and Adolescent counseling. Staff can help families or individuals with their problems with the following services:

- Individual/Family Counseling
- Group Counseling
- Clinical Assessment
- Substance Use Evaluations
- Case Management
- Psychiatric/Medication Management
- Outreach
- Consultation
- Education
- Emergency Services (24 Hr)
- Psychological Evaluations

Individual/Family Counseling

Therapist contact with clients and collaterals as necessary for the purpose of developing and implementing the treatment plan for the client.

Group Counseling

Therapist contact with two or more unrelated clients and collaterals as necessary for the purpose of implementing each child/adolescent's treatment plan.

Clinical Assessment

Therapist contact with clients and collaterals as necessary for the purpose of completing an evaluation of client's mental health disorders and treatment needs.

Substance Use Evaluations

This service is designed to ascertain whether or not a child/adolescent has a substance abuse or dependence problem. The severity of the disorder will determine what treatment recommendation is appropriate if any.
Procedures:

- Clinical interview
- Diagnostic instruments-Adolescent SASSI

Case Management

This service is used to assist individuals in gaining access to needed, medical, social, educational and other services.

Psychiatric/Medication Management Services

Prescription of and/or monitoring of the effects of psychotropic medications.

Outreach

Face-to-face or telephone contact with a person who would otherwise not seek services or their family members for the purpose of screening for service need and/or engaging in the potential client in mental health treatment.

Consultation

This is a case-centered or program centered service rendered to other human service agencies, health care professionals or human service oriented groups in order to assist them in meeting the substance abuse needs of their constituents who are not clients of CPCC.

Education

This is designed to increase the level of substance abuse knowledge or skills of lay public or specialized groups of individuals in the community.

Emergency Services

Emergency services are provided for residents of Washakie County. An on-call therapist is available 24/7 – CPCC works with local physicians, hospital emergency room staff and law enforcement officers to intervene in crisis situations.

Psychological Evaluations

A Psychologists evaluation of the child/adolescent's mental health disorders and treatment needs.

CPCC will address the special needs of persons seeking services including, interpretive services, community living skills, social skills, social supports and vocational supports.

CLIENT RIGHTS

- In accordance with Wyoming statutes, clients served by mental health centers have the right to impartial access to services, regardless of race, religion, sex, ethnicity, age, handicap, or sources of financial support.

- You have the right to have your personal dignity and privacy recognized and respected in the provision of all services.

- You have the right to receive services without worry about abuse, financial or other exploitation, retaliation, humiliation, and neglect from staff.

- As a Cloud Peak Counseling Center client, you have a right to an individual plan for your treatment which provides for the least restrictive care that may be expected to benefit you.

- Written and verbal communications between clients and staff and the content of clinical records shall be held in confidence by all staff. Confidential information shall be revealed or released only with the client's informed and written consent, instances of legally reportable child or adult abuse and neglect, client criminal activity on CPCC premises or against CPCC staff, and to qualified State and Federal personnel, and to authorized peer reviewers under written oath of confidentiality.

- Federal confidentiality rules (42-CFR Part 2 and CFR parts 160 and 164) prevent use of any information we have obtained to criminally investigate or prosecute any alcohol or drug patient. Disclosure of client identifying information is permitted if authorized by a court order, after application showing good cause.

- You have the right to initiate a grievance and obtain a mechanism for requesting a review of the grievance. You have the right to bring legal representation to the hearing to assist in presenting the grievance. Suggestions, complaints, or grievances should be taken to the Director of Cloud Peak Counseling Center; in the event of a grievance, you will be provided with a copy of our Client Grievance and Hearing Policy.

- You have the right to have access to your own records, except when CPCC feels it would not be in your best interests.

- You have the right to access legal entities for appropriate representation.

- You have the right to access self-help and advocacy support services.

- You have the right to be notified under what conditions these rights may be restricted including criteria for resolution and return to treatment.

Confidentiality

The Agency protects the confidentiality of all client related information, including the fact that a person is (or was) a client of the Agency. Confidential information is released only with the client's written permission, in a form that meets the requirements for informed consent, complies with federal HIPAA (Health Insurance Portability and Accountability Act) privacy guidelines, and/or in those specific situations where disclosure is mandated or permitted by law.

CLIENT RESPONSIBILITIES

- To provide true facts about your illnesses, medications and previous treatments.
- To report any changes in your medications or symptoms to your therapist/case manager.
- To ask questions about your care or treatment plan.
- To follow the recommendations/instructions of your therapist/case-manager.
- To realize that the problems caused by your failure to follow your treatment plan or therapist instructions are your responsibility.
- To pay your bills and work out financial arrangements for covering the cost of your treatment.
- To be considerate to other staff, visitors and other clients by respecting their rights and confidentiality.
- To notify your therapist or case-manager if you are unable to attend a scheduled appointment as soon as you become aware that you will not be able to attend it.

THERAPIST RESPONSIBILITIES

While receiving services from CPCC you may expect your therapist to be responsible for the following:

- To make every reasonable effort to help you gain insight, learn new skills, and teach behavioral tools.
- To respect the ethical guidelines of his/her profession.
- To abide by Cloud Peak Counseling Center's Code of Ethics.
- To respect the integrity and rights of all of his/her clients.
- To attend every scheduled session, to cancel session in advance when needed, and to reschedule whenever possible.
- To include you in decision making regarding your treatment.
- To hold in strict confidence all information revealed in therapy unless you are in danger of harming yourself or others, or unless the therapist is required under state or federal law to report any information (see Notice of Privacy Practice).
- To obtain therapy consultation when needed with a supervisor, peer group or member of your treatment team.

CLIENT GRIEVANCES POLICY AND PROCEDURE

POLICY:

As part of the intake procedure, Cloud Peak Counseling Center will provide to every person, requesting its services, a written statement that the person may take grievances, complaints or suggestions to the Executive Director. This information is contained in the "Application for Services" form.

Filing of a complaint or grievance shall not result in retaliation or be a barrier to services.

PROCEDURE:

1. An informal grievance, complaint or suggestion from any source will be referred to the Executive Director for action. If the person expressing the grievance, complaint or suggestion, is not satisfied with the Executive Director's action or decision, the person may choose to follow a formal grievance procedure. The Executive Director will inform the person of the procedure stated below and provide the person with a written copy.

2. A person wishing to submit a formal grievance must do so in writing to the Executive Director. The Executive Director will acknowledge receipt of the grievance in writing and take action within ten (10) working days from the receipt of said grievance. The Executive Director will inform the person submitting the grievance of the decision in writing.

3. If the person submitting a grievance wishes a review of the Executive Director's action, the person may refer the grievance in to the President of the Board of Directors and request a hearing. Before any release of records or review, the Board shall require a signed release of information by the person requesting a grievance hearing.

When the Board of Directors receives the written request for a grievance hearing, it will set a time and place for a hearing. This will be no later than thirty (30) days from the date it received the request for hearing.

The person requesting a hearing will receive a notice by certified mail telling him/her of the time and place of the hearing not less than ten (10) days before the date set for the hearing.

The person requesting a hearing will have the right to bring other persons to the hearing to assist in presenting the grievance. The Board of Directors will inform the person submitting the grievance of its decision by certified mail no later than twenty (20) days after the hearing.

CODE OF ETHICS

1. I will not discriminate against or refuse professional services to anyone on the basis of race, color, creed, age, sex, religion, disability or nationality.
2. I will not use my professional relationship to further my own business.
3. I will evidence a genuine interest in all persons served, and do hereby dedicate myself to their best interests and helping them help themselves.
4. I will respect the privacy of persons served and hold in confidence all information obtained in the course of professional service.
5. I will maintain confidentiality when storing or disposing of client records.
6. I will maintain a professional attitude which upholds confidentiality towards individuals served, colleagues, applicants and the agency.
7. I, upon termination, will maintain client and co-worker confidentiality, and I will hold as confidential any information I obtained concerning the agency.
8. I will respect the rights and views of my colleagues, and treat them with fairness, courtesy and good faith.

Code of Ethics Continued:

9. I will not exploit the trust of the public or my co-workers. I will make every effort to avoid relationships that could impair my professional judgment.
10. I will not engage in or condone any form of harassment or discrimination.
11. I will not permit fellow employees to present themselves as competent or perform services beyond their training and/or level of experience.
12. I will respect the confidences of my co-workers.
13. When I replace a colleague or am replaced, I will act with consideration for the interest, character and reputation of the other professional.
14. I will extend respect and cooperation to colleagues of all professions.
15. I will not assume professional responsibility for the clients of a colleague without appropriate consultation with that colleague.
16. If I see the client of a colleague during a temporary absence or emergency, I will serve that client with the same consideration afforded any client.
17. If I have the responsibility for employing and evaluating employees' performance, I will do so in a responsible, fair, considerate and equitable manner.
18. If I know that a colleague has violated ethical standards, I will bring this to my colleague's attention. If this fails, I will report the activity to my supervisor.
19. I will accurately represent my education, training, experience and competencies as they relate to my profession.
20. I will correct, when possible, misleading or inaccurate information and representations made by others concerning my qualification or services.
21. If serving as a supervisor, I will make certain that the qualifications of persons I supervise are honestly represented.
22. I will abide by the agency policies related to public statement.
23. I have total commitment to provide the highest quality of services to those who seek my professional assistance.
24. I will continually assess my personal strengths, limitations, biases and effectiveness.
25. I will strive to become and remain proficient in professional practice and the performance of professional functions.
26. I will act in accordance with standards of professional integrity.
27. I will not advise on problems outside the bounds of my competence.
28. I will seek assistance for any problem that impairs my performance.
29. I will practice ethical marketing, business activities, and avoid any conflict of interest that may be present or implied.
30. I understand that violation of this code may be grounds for dismissal.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Following are the Privacy Practices of Cloud Peak Counseling Center ("the Center") as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder (45 CFR Parts 160 and 164), and the Public Health Service Act (42 CFR Part 2 and 45 CFR parts 160 and 164) dealing with confidentiality of alcohol and drug abuse records.

Protected Health Information

The Center collects personal health information ("PHI") about clients through treatment, payment, and related health care operations, including the application and enrollment process, insurance companies or other healthcare providers, or other means. PHI that is protected by law includes any information that is created or received by health care entities and health care providers like the Center.

Generally, the Center, including its workforce and business associates, may not say to a person outside the Center that a client attends the Center, or disclose any information identifying a client except under certain circumstances as outlined below. The law protects health information that contains specific data, such as name, address, social security number, and other personal information that could be used to identify the client associated with that health information. The Center is allowed at any time to give out information that has been "de-identified", meaning that the information contains no data that could be used to identify the client associated with that information.

Uses or Disclosures of Personal Health Information

As a general rule, the Center will not use or disclose PHI without the affected client's permission. The Center will make every effort to obtain the client's permission if there is a need to use or disclose the client's information. Once that permission has been obtained, the Center will ONLY use or disclose PHI in accordance with the specific terms of that permission. Additional protections are provided for the privacy of clients who are receiving treatment for substance abuse.

However, there ARE circumstances where the Center is required by law to disclose information. In these circumstances, the Center will make every effort to obtain a client's permission before releasing the information. If that permission cannot be obtained, and if all legal requirements have been met by the person requesting the information, the Center will release the information according to the requirements of the law. Following are the circumstances under which the Center is permitted by law to use or disclose PHI.

With or Without Consent:

With or without a client's consent, the Center may use or disclose PHI in order to provide services and treatment required or requested, to collect payment for those services, and to conduct related health care operations permitted or required by law. The Center is permitted to disclose PHI within and among its workforce to accomplish these purposes. The Center has developed policies and procedures that limit which members of the workforce may have access to PHI for treatment, payment activities, and health care operations, based on need to access information in order to do a job. The Center is required to limit such uses or disclosures to the minimal amount of information that is reasonably required for payment activities and health care operations, but this minimum necessary standard does not apply to treatment purposes.

The Center may use PHI to provide appointment reminders and information about treatment alternatives or other health-related benefits and services that may be of interest to the client.

"Treatment" generally means the provision, coordination, or management of health care and related servi ces among health care providers, by a health care provider with a third party, or the referral of a client from one he alth care provider to another. For example, a counselor at the Center may use PHI about a client to provide he alth care to that client and may consult with another counselor or psychologist about treatment.

"Payment activities" encompass activities to obtain payment or to be reimbursed for services provided to a cli ent. Payment activities include billing and collection, processing insurance claims, and disclosures to consumer reporting agencies. For example, the Center may disclose PHI about a client as part of a claim for payment from a health or insurance plan.

"Health care operations" are administrative, financial, legal, and quality improvement activities that are necessary to run the business of the Center and to support the core functions of treatment and payment activities. For example, the Center may use PHI to arrange for medical review, legal, and auditing services, to train health care and non-health care professionals, to create de-identified health information or limited data sets, or to conduct fundraising activities for the benefit of the Center.

Without Written Authorization:

The Center may use or disclose PHI without a client's written authorization, or the opportunity for the client to agree or object, in the following situations:

Public Health Activities: The Center may use or disclose PHI to public health authorities who are authorized to receive such information for preventing, controlling, or reporting disease, injury, disability, or vital events such as birth or death, or for conducting public health surveillance, investigations, or interventions.

Child or Vulnerable Adult Abuse or Neglect: The Center, or any person, must, by state law, report child abuse or neglect, as well as abuse, neglect, exploitation, abandonment, or self-neglect of a vulnerable adult, to social services or law enforcement officials. A vulnerable adult is any person 18 years of age or older who is unable to manage and take care of himself or herself or his/her property without assistance as a result of advanced age or physical or mental disability.

Domestic Violence: The Center may disclose PHI about a client believed to be a victim of domestic violence to social services or a protective services agency if the client agrees to the disclosure or if the Center, in its professional judgment, believes disclosure is necessary to prevent serious harm to the client or others. The client will promptly be informed that such a report has been or will be made, except if the Center believes that informing the client would place him/her at risk of serious harm, or, if a personal representative of the client would be informed, the Center reasonably believes the personal representative is responsible for the domestic violence.

Health Oversight Activities: The Center may disclose PHI to a health oversight agency for such activities as audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities.

Judicial Proceedings: The Center must disclose PHI in response to an order of a court or administrative tribunal, but will disclose only the information expressly authorized by the order. The Center may disclose information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal under certain specific circumstances, and if an effort to inform the client has been made.

Wounds: The Center must report untreated gunshot wounds, knife wounds, and other types of suspicious physical injuries to law enforcement officials.

Law Enforcement: The Center must disclose PHI in compliance with a court order, subpoena, or summons issued by a judicial officer, a grand jury, or an administrative request if the information sought is relevant and material to a legitimate law enforcement inquiry, and if it meets certain requirements. The Center may disclose information in response to a law enforcement official's request regarding a client who is or is suspected to be a *victim of a crime* if the client consents to the disclosure or in certain situations including emergency circumstances. The Center may disclose PHI about a *client who has died* to a law enforcement official if the Center suspects that death may have resulted from criminal conduct. Information may be disclosed to a coroner or medical examiner to identify a deceased person or determine a cause of death, and to a funeral director as necessary. The Center may disclose

PHI to law enforcement officials that the Center believes in good faith constitutes evidence of *criminal conduct that occurred on the Center's premises.* In response to a *medical emergency,* the Center may disclose PHI to a law enforcement official if disclosure appears necessary to report the commission of a crime; the location or victim(s) of a crime; and the identity, description, and location of the perpetrator of a crime. Use or disclosure may be made to law enforcement authorities in order to identify or apprehend a client because of an admission by that client to participation in a violent crime that the Center believes may have caused serious physical harm to a victim, or where it appears that the client has escaped from a correctional institution or lawful custody, if the information was obtained under certain circumstances.

Correctional institutions: The Center may disclose PHI to a correctional institution or a law enforcement official having lawful custody of an inmate if such information is necessary for the provision of health care to the client; or for the health and safety of others. A client is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

Organ donations: The Center may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue with a written consent from the client, his/her personal representative, or family.

Employers: The Center may disclose information to an employer about an employee who has received health care at the request of the employer in order to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether the employee has a work-related illness or injury. The client will be provided with written notice at the time the health care is provided that PHI is being disclosed.

Workers' compensation: The Center may disclose PHI as necessary to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries or illness without regard to fault.

Research: The Center may use or disclose PHI for research under very specific circumstances. As a general rule, the Center rarely releases identifiable information for research purposes and then only with a client's permission

Threats to Health or Safety: The Center may use or disclose PHI if it believes it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and is to persons reasonably able to prevent or lessen the threat, including the target of the treat.

Military: The Center may use and disclose PHI of clients who are Armed Forces personnel or foreign military personnel for activities deemed necessary by appropriate military command authorities.

National Security Activities: The Center may use and disclose PHI to federal officials for lawful intelligence, counter-intelligence, and other national security activities such as protective services to the President, foreign heads of state, or others, as authorized by the National Security Act and any implementing authorities, such as executive orders.

Written Authorization Required:

Except as otherwise permitted or required, the Center may not use or disclose PHI without a valid written authorization from the affected client and may not condition the provision of treatment or payment on a written authorization, except for research-related treatment or treatment undertaken solely for creating information for disclosure to a third party. The Center is required to use or disclose information consistent with the terms of a valid written authorization. An authorization may be revoked in writing at any time, except to the extent that the Center has taken action in reliance on such authorization, or if the authorization was a condition of obtaining insurance coverage.

Psychotherapy Notes: Authorization is required for use or disclosure of psychotherapy notes, except for uses within the center for treatment purposes, training programs, or to defend itself in a legal action brought by the client. Psychotherapy notes may be used or disclosed without authorization to determine the Center's compliance with HIPAA, as required by law, or for health oversight activities pertaining to the originator of the notes. Use and disclosure may be made without authorization to avert a serious threat to health or safety and to provide information about a decedent to a coroner or medical examiner.

Marketing: Authorization is required for any use or disclosure of PHI for marketing, except when it is a face-to-face conversation by the Center to a client or a promotional gift of nominal value provided by the Center. The Center will also inform the client if any direct or indirect payment is made by a third party.

Uses and Disclosures Requiring an Opportunity to Agree or Object:

The Center may use or disclose PHI in the following instances when the affected client is informed in advance, either orally or in writing, and has the opportunity to agree, prohibit, or restrict the use or disclosure.

Facility directories: The Center does not and will not maintain a directory of clients.

Activities involving a client's care and notification: The Center may disclose to a family member, other relative, close personal friend, or any other person identified by the client, PHI directly relevant to that person's involvement with the client's care or payment activities. The Center may disclose information to notify a family member, personal representative, or other person responsible for the care of the client, of his/her location, general condition, or death. If the client is available and has capacity to make health care decisions, the Center may use or disclose information as described above if it obtains the client's agreement and provides an opportunity to object, or reasonably infers from the circumstances that the client does not object to the disclosure. If the client is not present, or the opportunity to agree or object cannot be provided because of incapacity or an emergency, the Center may determine whether disclosure is in the client's best interest and, if so, disclose only the information that is directly relevant to the person's involvement with the client's health care.

Disaster relief: The Center may use or disclose PHI to public or private entities authorized to assist in disaster relief efforts.

Client Rights With Respect to Personal Health Information

Affected clients have certain rights with respect to their PHI. The following is a brief overview of these rights:

Right To Request Restrictions on Uses or Disclosures:

Clients have the right to request restrictions on certain uses and disclosures of their PHI. Restrictions may be requested for uses and disclosures to (a) carry out treatment, payment, or healthcare operations; (b) family members, relatives, or close personal friends directly involved in care or payment activities; (c) permit other persons to pick up filled prescriptions, medical supplies, X-rays, or similar forms of PHI; or (d) a public or private entity authorized to assist in disaster relief efforts. While the Center is not required to agree to a restriction, if a restriction is agreed upon, the Center is bound by it, except in certain emergency situations. The Center may terminate its agreement to a restriction if the client agrees or requests the termination or the Center informs the client of the termination. Termination is effective only with respect to information created or received after the client has been informed. The Center will not accept a restriction for uses or disclosures required to determine compliance with the Privacy Rule or for which an authorization or an opportunity to agree or object is not required.

Right to Receive Confidential Communications:

An affected client has the right to receive confidential communications regarding their PHI. Requests must be in writing, and reasonable requests to receive the information by alternate means or at alternate locations will be accommodated. The Center may condition the provision of information on how payment, if any, will be handled, and specification of an alternative address or other method of contact. An explanation of the basis for the request will not be required.

Right to Inspect and Copy PHI: A designated record set is any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the Center, including medical and billing records. A client has a right to inspect and copy information contained in his/her designated record set, *except for* (a) psychotherapy notes; (b) information compiled in anticipation of a civil, criminal, or administrative action; and (c) information where access by the client is prohibited by law. These exceptions are unreviewable. Access to PHI created or obtained by the Center for research that includes treatment may be suspended for as long as the research is in progress, if the client has agreed when consenting to participate in the research and has been informed that right of access will be reinstated upon completion of the research. A client's access may be unreviewably denied, if the PHI was obtained from someone other than a health care provider under a promise of confidentiality and access would likely reveal the source of the information.

Reviewable grounds for denial of access occur when a licensed health care professional has determined that access would likely (a) endanger the life or physical safety of the affected client or another person; (b) cause substantial harm to another person if the information makes reference to that person; or, (c) if the request is made by a personal representative, access is likely to cause substantial harm to the affected client or another person. If access is denied on any of the above grounds, the client has the right to for a review by a licensed health care professional designated to act as a reviewing official and who did not participate in the original decision to deny.

The Center will, if possible, give the client access to any other PHI requested after excluding the information to which access is denied. Denials will be written and contain the basis for the denial, a statement of the client's review rights, how the client may exercise such rights, and how a complaint may be filed. If the Center does not maintain the PHI that is requested and knows where it is maintained, the client will be so informed.

The Center requires written requests for access to PHI. A request for access will be acted on no later than 30 days after receipt. If the information is not accessible on-site, action will take place no later than 60 days from receipt. Extensions will not exceed thirty 30 days, and the Center will provide a written statement of the reasons for the delay and the date action will be completed. Only one extension is allowed. The Center will provide a client with access to his/her PHI in the form requested if it is readily producible or in a readable hard copy or other format as agreed by the Center and client. The Center may provide a summary of the information requested in lieu of providing access, or may provide an explanation if the client agrees in advance to a summary or explanation and to the fees imposed. The Center will provide access as requested and will arrange a convenient time and place to inspect or obtain copies, or will mail a copy of the information. If the client requests a copy or agrees to a summary or explanation, the Center may charge a reasonable, cost-based fee for copying, postage, and the costs of preparing an explanation or summary, as agreed upon in advance.

Right to Amend PHI:

Clients have the right to request that the Center amend his/her PHI. The Center has the right to deny a request for amendment, if the information (a) was not created by the Center, (b) is not part of the client's designated record set, (c) is prohibited from access, or (d) is accurate and complete. Written requests from the client must provide a reason for the requested amendment. The Center will act on a request for an amendment within 60 days. This time may be extended once by 30 days if the client is given a written statement of the reasons for the delay and the date by which action will be complete.

If a request is denied, the Center will provide a timely written denial, stating the basis of the denial and explaining the rights of the client to take further action.

If the Center accepts a request for amendment, the amendment will be made. The Center will inform the client that the amendment is accepted and obtain the client's agreement to have notification of the amendment sent to relevant persons.

Copies of all requests, denials, statements of disagreement, and rebuttals will be included in the client's designated record set. All requests for amendment, statements of disagreement, and complaints shall be sent to the Executive Director.

Right To Receive an Accounting of Disclosures of PHI:

Clients have the right to receive a written accounting of all disclosures of PHI that the Center has made within a 6-year period immediately preceding the date on which the accounting is requested. Accountings will include the date of each disclosure, the name and address of the entity who received the information, a brief description of the information disclosed, and a statement of the purpose of the disclosure or, in lieu of such statement, a copy of the authorization or request for disclosure. *The Center is not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) pursuant to the client's authorization, (c) to the client, (d) to persons involved in a client's care, (e) for national security or intelligence purposes, (f) to correctional institutions or for some law enforcement purposes, (g) disclosures occurring prior to 4/14/03, (h) information sent as part of a limited data set, or (i) relating to investigations of the Center. The Center must temporarily suspend the right to receive an accounting of disclosures to health oversight agencies or law enforcement officials as required by law. Accountings will be provided in any 12 month period without charge, but a reasonable, cost-based fee will be imposed for responding to subsequent requests for accounting within that same 12 month period. All requests for an accounting shall be sent to the Executive Director. The Center will act on a request for an accounting of disclosures within 60 days after receipt. This time may be extended once by no more than 30 days if a written statement of the reasons for the delay and the date by which the requested action will be completed is given.

Legal Duties of Cloud Peak Counseling Center

The Center is required by law to maintain the privacy of PHI and to provide clients with notice of its legal duties and privacy practices. The Center is required to abide by the terms of this Privacy Notice.

Revisions or Amendments:

The Center reserves the right to revise or amend this Notice of Privacy Practices at any time. Revisions or amendments will reflect changes in State and Federal law protecting privacy and confidentiality and any changes in the Policies and Procedures of the Center. Revisions or amendments may be effective for all PHI the Center maintains even if created or received prior to the effective date of the revision or amendment. Notice will be provided of any revisions or amendments to this Notice of Privacy Practices, or changes in the law affecting this Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

Complaints

Complaints may be filed with the Center and with the Secretary of the Department of Health and Human Services (DHHS) if a client believes that any privacy rights have been violated. Complaints must be in writing, may be on the form provided by the Center, and may be filed by mail or electronically to the Center's privacy officer, James Donahue, at 401 South 23rd Street, Worland, WY 82401 or (307) 347-6165. A complaint must name the entity or person that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of the law or this Notice. A complaint must be received by the Center or filed with the Secretary of DHHS within 180 days of when the client knew or should have known that the act or omission occurred. Clients will not be retaliated against for filing any complaint. Complaints sent to the Secretary of DHHS should be sent to:

The US Dept. of Health & Human Services
Office of the Secretary
200 Independence Ave., SW
Washington, DC 20201

Violation of Federal law and regulations regarding the confidentiality of client records is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. The Center will provide the necessary information for such reporting upon request.

On-going Access to the Notice of Privacy Practices

The Center will provide a copy of the most recent version of this Privacy Notice at any time upon written request sent to James Donahue at 401 South 23rd Street, Worland, WY 82401. Clients may obtain a paper copy of this Notice upon request, even if he/she has agreed to receive the Notice electronically. For any other requests or for further information regarding the privacy of PHI, and for information regarding the filing of a complaint, please contact our privacy officer, James, at the address or telephone number listed above.

Fee Grid

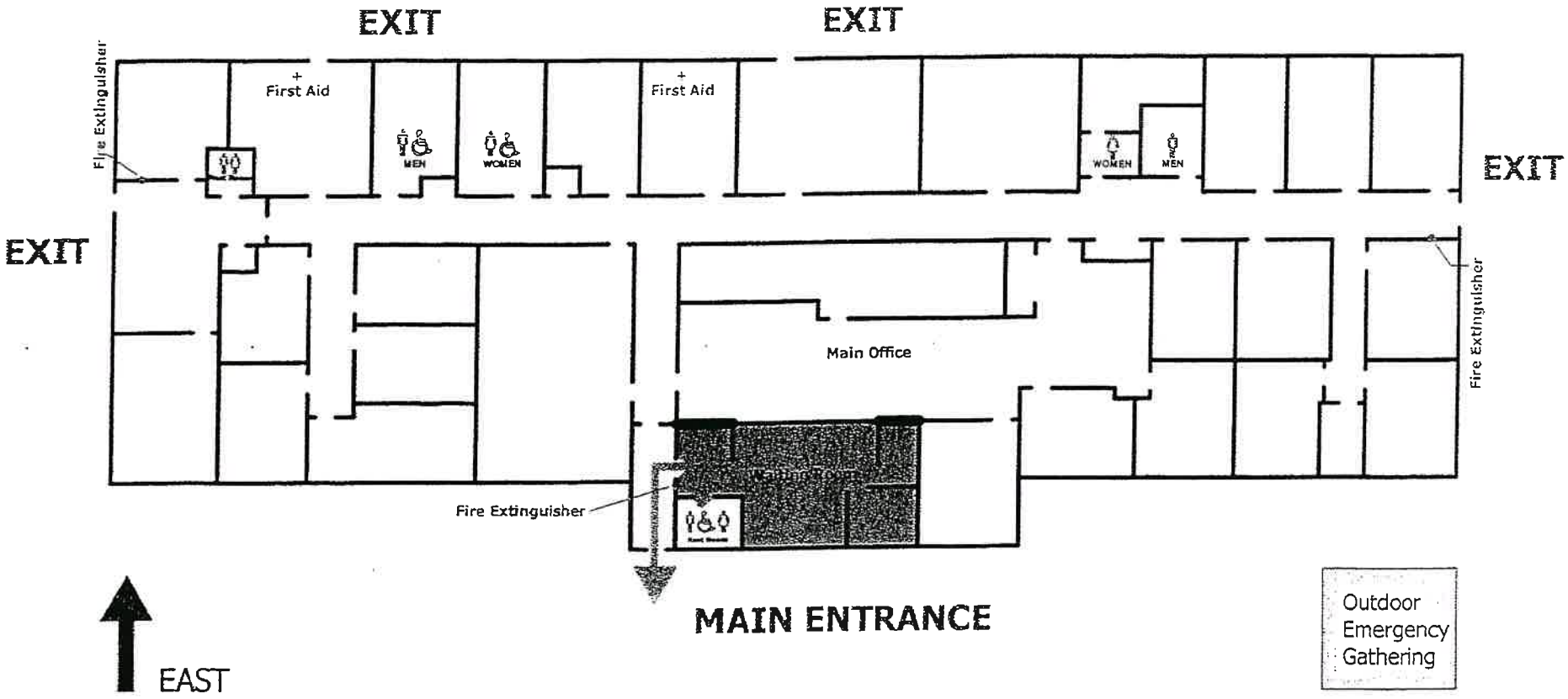
MD	Full Fee	90%	80%	70%	60%	50%	40%	30%	20%	10%
96101- Psychiatric Evaluation	$165.34	$148.81	$132.27	$115.74	$99.20	$82.67	$66.14	$49.60	$33.07	$16.53
90792- Psychiatric Med Mgt	$329.34	$296.41	$263.47	$230.54	$197.60	$164.67	$131.74	$98.80	$65.87	$32.93

APRN	Full Fee	90%	80%	70%	60%	50%	40%	30%	20%	10%
99203- Med Mgt New Client Detailed Low	$183.34	$165.01	$146.67	$128.34	$110.00	$91.67	$73.34	$55.00	$36.67	$18.33
99204- Med Mgt New Client Comp. Mod	$279.93	$251.94	$223.94	$195.95	$167.96	$139.97	$111.97	$83.98	$55.99	$27.99
99205- New Med Mgt Client Comp. High	$346.44	$311.80	$277.15	$242.51	$207.86	$173.22	$138.58	$103.93	$69.29	$34.64
99212- Med Mgt Estab. Straightforward	$74.60	$67.14	$59.68	$52.22	$44.76	$37.30	$29.84	$22.38	$14.92	$7.46
99214- Established Client	$181.03	$162.93	$144.82	$126.72	$108.62	$90.52	$72.41	$54.31	$36.21	$18.10
90833- Med Mgt Therapy 30min	$70.55	$63.50	$56.44	$49.39	$42.33	$35.28	$28.22	$21.17	$14.11	$7.06
90836- Med Mgt Therapy 45 min	$114.51	$103.06	$91.61	$80.16	$68.71	$57.26	$45.80	$34.35	$22.90	$11.45
90838- Med Mgt Therapy 60 min	$184.50	$166.05	$147.60	$129.15	$110.70	$92.25	$73.80	$55.35	$36.90	$18.45
90792- Med Mgt New Client Assessment	$329.34	$296.41	$263.47	$230.54	$197.60	$164.67	$131.74	$98.80	$65.87	$32.93

Therapist	Full Fee	90%	80%	70%	60%	50%	40%	30%	20%	10%
90791- Assessment	$226.05	$203.45	$180.84	$158.24	$135.63	$113.03	$90.42	$67.82	$45.21	$22.61
90785- Interactive Complexity	$7.14	$6.43	$5.71	$5.00	$4.28	$3.57	$2.86	$2.14	$1.43	$0.71
90832- Therapy 30 Min	$93.90	$84.51	$75.12	$65.73	$56.34	$46.95	$37.56	$28.17	$18.78	$9.39
90834- Therapy 45 Min	$120.94	$108.85	$96.75	$84.66	$72.56	$60.47	$48.38	$36.28	$24.19	$12.09
90837- Therapy 60 Min	$197.32	$177.59	$157.86	$138.12	$118.39	$98.66	$78.93	$59.20	$39.46	$19.73
90847/H0004- Family Therapy w/ Client	$132.68	$119.41	$106.14	$92.88	$79.61	$66.34	$53.07	$39.80	$26.54	$13.27
90846/H0004- Family Therapy w/o Client	$110.72	$99.65	$88.58	$77.50	$66.43	$55.36	$44.29	$33.22	$22.14	$11.07
90853- Group Therapy (Per hour)	$50.00	$45.00	$40.00	$35.00	$30.00	$25.00	$20.00	$15.00	$10.00	$5.00
H2014- Peer Specialist Individual	$32.50	$29.25	$26.00	$22.75	$19.50	$16.25	$13.00	$9.75	$6.50	$3.25
99409- SA Evaluation	$150.00									

Cloud Peak Counseling Center

401 South 23rd Street
Worland, Wyoming 82401



CLOUD PEAK COUNSELING CENTER

COVID-19 RISK INFORMED CONSENT

I _____ (client name) understand that I am opting for an in-person appointment.

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing.

I recognize that my individual provider and all the staff at Cloud Peak Counseling Center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with an in-person service.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this one-on-one session.

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Cloud Peak Counseling Center

Informed Consent for Telehealth Consultations

Healthcare services in Mental Health(MH) and/or Substance Abuse(SA) are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth", this means that I may be evaluated and treated by a MH or SA healthcare provider or specialist from a different location. Since this is different than the type of session/service with which I am familiar, **I understand and agree to the following:**

1. The consulting MH or SA healthcare provider or specialist will be at a different location from me.
2. The MH or SA healthcare provider may transmit or share electronically details of my MH or SA history, assessments, diagnosis, treatment, photographs or other images with myself or other designated person(s) as listed on a completed Release of Information(ROI).
3. I will be informed if any additional personnel are to be present other than myself during sessions. I will inform the MH or SA Healthcare provider of anyone accompanying me in the session. I will give my verbal permission prior to start of session/service of any additional personnel or individuals being present.
4. The MH or SA healthcare provider for whom treatment is performed will keep a record of the session/service in my chart record/file.

Noting all the above, I understand that my participation in the process described called "telemedicine" or "telehealth", is voluntary. I understand all possible precautions to ensure safety of my personal information are taken by the MH or SA healthcare provider however, there is a possibility of increased risk of disclosure of my personal data utilizing "telehealth".

I further understand that I have the right to:

1. Refuse the telehealth session/service, or stop participation in the telehealth session/service at any time.
2. Request that the presenting MH or SA healthcare provider refrain from transmitting my information if I make the request before the information is transmitted.
3. Request that other personnel leave the room(s) at any time.

I acknowledge that the MH or SA healthcare providers involved have explained the session/service in a satisfactory manner and that all questions that I have asked about the sessions/services have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the "telehealth" process described above.

Client signature:_____ Date:_____

Client representative:_____ Date:_____

Witness signature:_____ Date:_____

Client name:_____

Primary Care Provider or Case Manager:_____

PHQ-9 & GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 – Total Score

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Symptom Checklist

Name:_____ Date:_____

Please check the appropriate degree of any symptoms you have experienced in the last month.

1=Never 2=Rarely 3=Occasionally 4=Frequently 5=Usually

Constant sadness/depressed mood	☐1	☐2	☐3	☐4	☐5
Difficulty falling asleep	☐1	☐2	☐3	☐4	☐5
Early morning awakening	☐1	☐2	☐3	☐4	☐5
Waking during the middle of the night	☐1	☐2	☐3	☐4	☐5
Increased sleep	☐1	☐2	☐3	☐4	☐5
Decreased enjoyment in formerly pleasurable activities	☐1	☐2	☐3	☐4	☐5
Feelings of guilt	☐1	☐2	☐3	☐4	☐5
Low self esteem	☐1	☐2	☐3	☐4	☐5
Feelings of helplessness	☐1	☐2	☐3	☐4	☐5
Feelings of hopelessness	☐1	☐2	☐3	☐4	☐5
Fatigued/low energy	☐1	☐2	☐3	☐4	☐5
Decreased concentration	☐1	☐2	☐3	☐4	☐5
Indecisiveness/slowed thinking	☐1	☐2	☐3	☐4	☐5
Appetite ☐ up/ ☐ down	☐1	☐2	☐3	☐4	☐5
Weight ☐ up/ ☐ down How much?____lbs	☐1	☐2	☐3	☐4	☐5
Crying spells	☐1	☐2	☐3	☐4	☐5
Suicidal thoughts	☐1	☐2	☐3	☐4	☐5
Attempts to hurt self/cutting on self	☐1	☐2	☐3	☐4	☐5
Diminished sex drive	☐1	☐2	☐3	☐4	☐5
Tendency to isolate	☐1	☐2	☐3	☐4	☐5
Needing to be with others excessively	☐1	☐2	☐3	☐4	☐5
Difficulty with relationships (spouse, children, co-workers)	☐1	☐2	☐3	☐4	☐5
Decreased effectiveness at work/home	☐1	☐2	☐3	☐4	☐5
Overeating/Binge eating	☐1	☐2	☐3	☐4	☐5
Anorexia	☐1	☐2	☐3	☐4	☐5
Purging food (vomiting or laxatives)	☐1	☐2	☐3	☐4	☐5
Dramatic mood swings	☐1	☐2	☐3	☐4	☐5
Increased energy	☐1	☐2	☐3	☐4	☐5
Feeling elated	☐1	☐2	☐3	☐4	☐5
Racing thoughts	☐1	☐2	☐3	☐4	☐5
Overspending	☐1	☐2	☐3	☐4	☐5
Increased sexual activities	☐1	☐2	☐3	☐4	☐5
Decreased need for sleep	☐1	☐2	☐3	☐4	☐5
Alcohol use/abuse or dependency	☐1	☐2	☐3	☐4	☐5
Other drug use/abuse or dependency	☐1	☐2	☐3	☐4	☐5
Concerns about alcohol use	☐1	☐2	☐3	☐4	☐5
Family/legal problems due to alcohol/drugs	☐1	☐2	☐3	☐4	☐5

Fear of bridges/heights/ social situations	☐1	☐2	☐3	☐4	☐5
Feelings of anxiety	☐1	☐2	☐3	☐4	☐5
Feeling on edge	☐1	☐2	☐3	☐4	☐5
Panic attacks	☐1	☐2	☐3	☐4	☐5
Trembling/shakiness	☐1	☐2	☐3	☐4	☐5
Restlessness	☐1	☐2	☐3	☐4	☐5
Irritability	☐1	☐2	☐3	☐4	☐5
Shortness of breath	☐1	☐2	☐3	☐4	☐5
Heart palpitations/chest pain	☐1	☐2	☐3	☐4	☐5
Sweats	☐1	☐2	☐3	☐4	☐5
Dizziness	☐1	☐2	☐3	☐4	☐5
Nausea/abdominal distress	☐1	☐2	☐3	☐4	☐5
Headaches	☐1	☐2	☐3	☐4	☐5
Feeling dissociated	☐1	☐2	☐3	☐4	☐5
Menstrual problems/changes	☐1	☐2	☐3	☐4	☐5
Urinary problems	☐1	☐2	☐3	☐4	☐5
Sexual problems	☐1	☐2	☐3	☐4	☐5
Unexplained pain	☐1	☐2	☐3	☐4	☐5
Other physical symptoms	☐1	☐2	☐3	☐4	☐5
Decreased ability to sustain focus	☐1	☐2	☐3	☐4	☐5
Difficulty in organizing tasks	☐1	☐2	☐3	☐4	☐5
Forgetfulness	☐1	☐2	☐3	☐4	☐5
Distractibility	☐1	☐2	☐3	☐4	☐5
Feeling "hyper", restless or wound up	☐1	☐2	☐3	☐4	☐5
Impulsive	☐1	☐2	☐3	☐4	☐5
Amnesia	☐1	☐2	☐3	☐4	☐5
Feelings of numbness	☐1	☐2	☐3	☐4	☐5
Nightmares	☐1	☐2	☐3	☐4	☐5
Bizarre/unusual experiences	☐1	☐2	☐3	☐4	☐5
Hearing/seeing things others do not	☐1	☐2	☐3	☐4	☐5
Repetitive bothersome thoughts	☐1	☐2	☐3	☐4	☐5
Repetitive behaviors/compulsions	☐1	☐2	☐3	☐4	☐5
Difficulty with control of anger	☐1	☐2	☐3	☐4	☐5
Homicidal thoughts/hurting others	☐1	☐2	☐3	☐4	☐5
Attempts to hurt others	☐1	☐2	☐3	☐4	☐5
Have actually hurt others	☐1	☐2	☐3	☐4	☐5

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Treatment Planning

Please complete the following questions to assist us in accomplishing your treatment goals.

What are the main problems for which you are seeking help?

1. _____
2. _____
3. _____

What would you like to achieve by coming to therapy?

_____

_____

_____

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Consent to Treat

I have chosen to receive mental health services from Cloud Peak Counseling Center. My decision is voluntary and I understand that I may terminate these services at any time.

Nature of Mental Health Services

I recognize that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems.

Compliance With Treatment Plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent participation is essential to the success of my treatment.

Medication Management Appointments

I understand that I am willingly participating in the suggested treatment for Medication Management services. I recognize that I will be informed of the recommended medication purposes and the potential side effects. This explanation will include a clarification of the side effects/symptoms and the varying degrees of severity. With this information I acknowledge that Cloud Peak Counseling Center or any of its affiliates are not liable if the occurrence of these side effects/symptoms arise.

I have read, discussed and understood all of the above.

_____

Signature / Date

_____

Witness / Date