

WYOMING BEHAVIORAL INSTITUTE
PATIENT INFORMATION FORM

PRIMARY INSURANCE

Name of Insurance _____
Name of policy holder _____
Policy holder SS# _____ DOB: _____

SECONDARY INSURANCE

Name of Insurance _____
Name of policy holder _____
Policy holder SS# _____ DOB: _____

PATIENT INFORMATION:

FULL LEGAL NAME: _____
LAST FIRST MIDDLE Prefers to go by

ADDRESS: _____

MAILING ADDRESS (it different): _____

City State ZIP County ()

HOME PHONE

SOCIAL SECURITY NUMBER

AGE: _____ DATE OF BIRTH _____ SEX: **M F** RACE _____

MARTIAL STATUS: _____ RELIGION _____ Place Of Birth _____

PATIENT EMPLOYER: _____ PHONE: _____

ADDRESS: _____ STATUS: FULL PART

FAMILY PHYSICIAN: _____ CITY: _____

HAVE YOU EVER BEEN A PATIENT UNDER ANY OTHER NAME?

WHAT NAME? _____

LEGAL GUARDIAN: FULL NAME: _____ Relationship: _____

ADDRESS: _____

MAILING ADDRESS (it different): _____

HOME Phone: () _____

City State ZIP

EMPLOYER: _____ WORK Phone: _____

ADDRESS: _____ STATUS: FULL PART

EMERGENCY CONTACT: (next of kin)

NAME: _____

Relationship: _____

ADDRESS: _____

city ST ZIP

HOME Phone: _____

WORK Phone: _____

Nearest relative not living with you

NAME: _____ R

relationship: _____

ADDRESS: _____

city ST ZIP

HOME Phone: _____

WORK Phone: _____

**WYOMING BEHAVIORAL INSTITUTE
2521 E. 15TH STREET
CASPER, WY 82609
(307) 237-7444**

PATIENT NAME: _____ MR#: _____ DATE: _____

1. I authorize Dr. _____, and whomever she/he may designate as his/her assistants, to provide me with medical/psychiatric/chemical dependency treatment and to provide such additional procedures/treatment as she/he or they may deem reasonable and necessary to enhance the likelihood of achieving care, treatment and service my goals.
2. I further request and authorize the aforesaid physician(s) to make arrangements for radiology, laboratory, psychological services, procedures, and treatments as they may deem reasonable and necessary for my care. ***I AM AWARE SOME OF THE SERVICES MAY BE RENDERED FROM CONSULTATIVE FACILITIES AND/OR PERSONNEL AND THAT I MAY BE RESPONSIBLE FOR PAYMENT TO THESE CONSULTANTS.***
3. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantee, promises, or assurances have been made as to the results or examination in the hospital. Reasonable alternatives for care have been discussed with me.
4. In the event that I experience a medical crisis, I understand arrangements will be made to transport me to the Emergency Room of Wyoming Medical Center for care.

CONDITION OF ADMISSION

1. **MEDICAL/PSYCHIATRIC/CHEMICAL DEPENDENCY TREATMENT CONSENT:** The patient care is under the direction of his /her attending physicians, and the hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any radiology examination, laboratory procedures, medical/psychiatric/chemical dependency treatment of hospital services rendered to the patient under the general and special instructions of the physician. I, undersigned, recognize that all doctors of medicine providing services to the patient, including radiologist and other professionals, may be independent contractors and not employees or agents of the hospital.

2. **PATIENT CONFIDENTIALITY:** I understand that my information and my medical record will be kept in the utmost confidential manner. Information will be released only with my written authorization or under the Tarasoff Case rules of "duty to warn." This requires healthcare professionals to warn person(s) of threats by a patient. "Privacy ends when peril to the public begins."

2a. CONFIDENTIALITY OF MINORS: To provide the best therapeutic setting for my child. I, the undersigned, agree to allow therapeutic content to remain confidential between my child and the treatment team. I understand that I may ask for and receive explanations of treatment process/progress. I am also aware that under Wyoming Statute 20-2-113 (f), a non-custodial parent has the same right to access to healthcare records as the custodial parent/guardian unless otherwise ordered by the court.

2b. RECORDS RELEASE FOR INSURANCE: I hereby authorize the hospital to disclose medical/psychiatric/chemical dependency treatment information, which may include alcohol/drug abuse and mental health records obtained in the course of my diagnosis and treatment, to any person or corporation which is or may be liable under contract to the hospital, for all or part of the hospital's charges, including hospital or medical service companies, insurance companies, worker's compensation carriers and/or Medicare/Medicaid funds. This consent is subject to revocation by me at any time (in writing), except to the extent action has been taken in reliance thereon, and unless earlier revoked, shall expire upon final payment in full of the hospital's charges related to this admission.

3. **PROPERTY DAMAGE:** Any damage to the hospital property caused by myself or the patient I am signing for will be billed to my account for the cost of repairs or replacement.

WYOMING BEHAVIORAL INSTITUTE
2521 EAST FIFTEENTH STREET
CASPER, WYOMING 82609
307-237-7444

FINANCIAL PROCEDURES AND PRACTICES

Patient Name _____

INTRODUCTION

We recognize the importance of providing you with a clear explanation of procedures and practices related to the cost of your treatment. This information contains basic procedures and practices regarding the financial aspect of your treatment at our facility. Our business office is available Monday through Friday, 8:00 a.m. to 5:00 p.m. to address any additional concerns or questions you may have prior to or during your treatment.

RECORDS RELEASE FOR INSURANCE

I hereby authorize the hospital to disclose medical/psychiatric/chemical dependency treatment information, which may include alcohol/drug-abuse and mental health records obtained in the course of my diagnosis and treatment, to any person or corporation which we may be liable under contract to the hospital, for all or part of the hospital's charges, including hospital or medical service companies, insurance companies, Workers Compensation carriers, collections and/or Medicare/Medicaid funds. This consent is subject to revocation by me at anytime in writing, except to the extent action has been taken in reliance thereon, and unless earlier revoked, shall expire on final payment in full on the hospital's charges related to this admission.

CHARGES FOR TREATMENT

Please be aware that certain professional services rendered during your stay may be provided by physicians and mental health professionals who are independent providers and are not employees or agents of the hospital. These fees will be billed to you directly by the physician or provider who performs the services. **Dr. Brown is an independent provider. You will be receiving a separate billing from his office.**

RESPONSIBILITY FOR PAYMENT

All insurance plans are private contracts between individuals and their insurance company. While we will do everything in our scope of abilities to secure payment from your insurance company, ultimately the responsibility for payment is yours. As a courtesy we will bill your insurance company for you. If we have not received payment from your insurance company within 45 days after they have received the claim, you will become responsible for the charges and a payment arrangement will be made. ***If your insurance company denies any services, you agree to pay out of pocket for those unauthorized services.*** For any portion of the bill that becomes your responsibility, we accept Visa and Master Card credit cards. Should the account be referred to an outside agency or attorney for collection you will be responsible for the attorney fees, interest, and collection expenses allowable by law. Please inform the business office immediately if there are any changes in your address, phone number, employment, or insurance information so that we may keep your records updated.

CONCLUSION

If you have any questions regarding any services or programs we may offer, contact the intake department. If you have any questions regarding our financial procedures and practices, please contact the business office. Thank You.

I certify that I have read and understand the financial procedures and practices.

Patient/Guarantor _____ Date: _____

Witness _____ Date: _____

**WYOMING BEHAVIORAL INSTITUTE
2521 EAST FIFTEENTH STREET
CASPER, WYOMING 82609
307-237-7444**

Patient Name _____

1. Do you have any insurance coverage that may pay for this hospitalization, whether it be your own policy, spouses coverage on you or any other individual who may have a policy on you? Yes No

If yes, please present your insurance card.

2. Do you have Medicaid Yes No
Medicare Yes No

3. Do you have Workers Compensation coverage that is related to this hospitalization?
Yes No

4. Do you have any Governmental, Champus/Tricare or Veterans Administration Benefits that may cover this hospitalization? Yes No

5. Is this admission voluntary or involuntary? _____

6. If you answered no to the preceding questions, do you/spouse have the ability to pay for this admission?
Yes No

7. If the answer to question #6 is no, you must obtain the following information In order for us to determine if you are eligible for any Natrona County programs we may have to help you with your financial obligation (if you are a Natrona County resident). This information must be returned within 10 days from the date of your discharge.

- Copy of prior years income tax return or W-2
- Copy of paycheck stubs or proof of income for the last 3 months

Until you comply with these requirements you will be responsible for the charges and will be payable within 10 days of receipt of an itemized statement.

Signature

Date

Witness

Date

WYOMING BEHAVIORAL INSTITUTE
RELEASE/REQUEST FOR HEALTH INFORMATION

PATIENT NAME

DATE OF BIRTH

I hereby consent and authorize: **WYOMING BEHAVIORAL INSTITUTE, 2521 E. 15TH, CASPER, WY 82609**

- to release to
 receive from

NAME: _____

ADDRESS: _____

I understand that the information to be released includes information regarding **Medical, Mental Health, Chemical Dependency and HIV/AIDS** conditions.

INFORMATION

I authorize the following information to be released/requested:

- | | |
|---|-------------------------------|
| _____ DISCHARGE SUMMARY | _____ PSYCHOLOGICAL TESTING |
| _____ PSYCHIATRIC EVALUATION | _____ MEDICATION INFORMATION |
| _____ HISTORY/PHYSICAL EXAM | _____ TREATMENT PLAN |
| _____ LABS/X-RAY/EKG/MRI/EEG (including HIV/AIDS) | _____ EDUCATIONAL EVALUATIONS |
| _____ CONSULTATIONS | _____ VERBAL COMMUNICATIONS |
| _____ PHYSICIAN OUTPT NOTES | _____ OTHER (SPECIFY) _____ |

(I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE, INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING: FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY AND TREATMENT HISTORY; AND HIV / AIDS)

PURPOSE:

I understand that the information will be used for:

- _____ Further evaluation and treatment.
_____ Other _____

I understand that my behavioral health treatment records (including drug and alcohol) and information are protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2, and the HIPAA Privacy Rule, 45CRF, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations I hereby release both the above parties from any liability which may result from furnishing the information released or requested. Without my expressed **written** revocation, this consent will expire in SIX (6) months from date signed.

If the patient is under the age of 18 and has had drug and/or alcohol diagnosis, treatment or education, Federal Regulations require us to obtain the signature of BOTH the minor and parent/guardian.

Patient Signature

Date

Signature of Legal Guardian (For Minor or Incompetent Patients)

Date

Witness

Date

**WYOMING BEHAVIORAL INSTITUTE
2521 EAST FIFTEENTH STREET
CASPER, WYOMING 82609
307-237-7444**

CONTACT FORM

PT NAME: _____

ID CODE: _____

PLEASE COMPLETE THIS PORTION LISTING PERSON(S) THAT WYOMING BEHAVIORAL INSTITUTE MAY **ACKNOWLEDGE THE PATIENT.**

Please ✕ for Approval

| Date Added | Date Deleted | PERSON/FAMILY MEMBER NAME | PHONE NUMBER | RELATIONSHIP TO PATIENT | PHONE CALLS ✕ | VISITS ✕ | AUTHORIZED BY |
|------------|--------------|---------------------------|--------------|-------------------------|---------------|----------|---------------|
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Please contact this person in case of a medical emergency, seclusion or restraint.

NAME: _____ RELATIONSHIP _____ PHONE: _____

I hereby consent to **VERBAL** acknowledgment of the above named patient to maintain contact with family and friends who may or may not be involved in the patient's treatment. (If a person is not listed on this sheet, we will not speak with the caller or allow the patient to speak to the caller) **EXCEPTION: per Wyoming Statutes, a non-custodial parent has the same right to information on a minor as a custodial parent.**

I further consent to **VERBAL** contact regarding treatment progress with the above named people during the patient's treatment.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF LEGAL GUARDIAN

DATE

SIGNATURE OF WITNESS

DATE

This consent shall be in effect for thirty (30) days from the date of the above named patient's **DISCHARGE** from this facility. I understand that this consent is subject to revocation at any time upon written notification by the above named patient or legal guardian to **WYOMING BEHAVIORAL INSTITUTE** except in those circumstances in which the HOSPITAL has taken certain actions on the understanding that the consent will continue unrevoked for the purpose for which the consent was given have been accomplished.

WYOMING BEHAVIORAL INSTITUTE
Behavioral Interventions
Patient and Family Handout

Wyoming Behavioral Institute is a Joint Commission Accredited Health Care Facility and is committed to protecting patients' rights. Our goal is to create a physical/social and cultural environment that protects patients from hurting themselves or others while they are in treatment. It is our goal to protect patients' health and safety and preserve dignity, rights and wellbeing.

In the event that a patient's behavior becomes more aggressive or threatening to others in the environment, interventions are made to effectively deescalate and/or redirect behavior. Wyoming Behavioral Institute employees are trained annually in the areas of verbal de-escalation, management of aggressive and violent behavior, and in the care of patients who require physical containment for behavior control. It is our philosophy to utilize the least restrictive behavioral interventions possible to contain aggressive behavior. Some examples of interventions that have been approved by our Medical Staff and Board of Directors:

1. Redirect the patient from inappropriate to an appropriate behavior.
2. Conducting a 1:1 discussion with the patient (any staff member).
3. Asking the patient to take a time out in their room for a short, specified period of time (any staff member).
4. Providing environmental situations that will help the patient to calm themselves, e.g., music, a walk with staff, punching a pillow, etc. (any staff member).
5. Asking the patient to take a time out in the quiet room (any staff member).
6. Administering medication (Registered Nurse or LPN).
7. Restrain under the direction of a Registered Nurse with a physician order.
8. Seclusion under the direction of a Registered Nurse with a physician order.

Restraint is defined as any method of restricting a patient's freedom of movement or physical activity. Often staff using therapeutic holds for a short time until the "out of control behavior" has subsided accomplishes this. If a physical hold is not enough to contain the behavior, staff that is trained and competent may apply soft wrist and ankle restraints.

Seclusion is defined as the involuntary, solitary confinement of a patient in a room from which the patient is physically prevented from exiting. This is usually a locked room. A patient in restraints or seclusion remains under constant supervision. They are provided with food, water, bathroom and other basic care needs as indicated. It is our goal to minimize the use of restraints or seclusion and ask for your assistance and support to achieve our goal. If you are the patient or family member, you can help by providing our health care staff with information that will help calm the patient when he/she is having a difficult time or losing control. It is important to remember that restraints or seclusion are only initiated as an emergency measure when it is essential to protect patients from harming themselves, other patients, or staff. Parents/legal guardians will be called if their child requires seclusion or restraints. For our adult patients, family will be notified if consent to do so is given by the patient. The patient is told why they are in restraints or seclusion and what needs to occur to be removed from seclusion or restraints. Once the dangerous behavior has subsided, the patient is released from restraints or seclusion and the staff provides an opportunity to talk about why this intervention was needed and what techniques or approaches the patient could use in the future to better control behavior.

It is our wish to provide you and your loved ones with the best possible mental health/substance abuse care available. If you have questions, please ask you physician, the registered nurse or your therapist. Thank you for your time and attention to this matter and we wish you a quick and early recovery.

I have read the above information.

Patient Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

WYOMING BEHAVIORAL INSTITUTE
2515 E. 15th Street
Casper, WY 82609
(307) 237-7444

A PATIENT GUIDE
WAYS TO HELP PREVENT MEDICAL ERRORS

Providing quality care and treatment for your health care needs takes more than just an educated physician and an experienced staff. It is a team effort that requires your involvement and interest. You must be an active, responsible participant in order to receive the best care and treatment possible. Here are several ways you can help:

In General

1. Ask questions. It is all right to speak up and ask questions about every aspect of you or your child's care and treatment. You should expect answers from everyone involved in your or your child's care.
2. We want you to feel comfortable asking questions and discussing all areas of you or your child's health with your physician. If for some reason you are not comfortable, please let your physician know.
3. Before seeing your or your child's physician, make a list of questions about you or your child's condition or symptoms and take the list with you on your visit. This can help jog your memory and may lead to additional questions during the visit.
4. Consider taking a family member or close friend with you on visits if you feel it will help you remember the information and answers the professional gives you.
5. Learn more about current treatment for specific disorders from outside sources. Get research and background information from agencies and organizations such as the American Psychiatric Association or the American Academy of Child and Adolescent Psychiatry (www.aacap.org, Facts for Families), which offers treatment recommendations based on the latest scientific evidence.

Medications

6. Tell your or your child's doctor about all the medications you or your child takes, especially if a different physician prescribes them. Include over-the-counter medications such as aspirin and ibuprofen as well as vitamins, herbal supplements and weight loss products.
7. Alert your or your child's doctor or nurse about allergies to medications and other products often used, such as latex. Also alert nursing staff involved in you or your child's care.
8. Tell the doctor and nurses about adverse reactions to any medications that you or your child has taken in the past, no matter how long ago it occurred
9. When you or your child's doctor writes you a prescription, make sure that you can read it. If you cannot read you or your child's doctor's handwriting, your pharmacist may not be able to, either. Also ask about generic alternatives that might be given.
10. Ask your or your child's doctor about the medication being prescribed. How will it help? How should the medicine be used, and what is the dosage?
11. Ask your or your child's doctor or nurse for information about all medicines in terms you can understand:
 - a. What is this medicine for?
 - b. How much should he/she take? For how long?
 - c. Is this medicine safe to take with other medications or dietary supplements?
 - d. What food, drink or activity should be avoided while on the medication?
 - e. What side effects should be expected and how should they be handled?
12. When you pick up your or your child's prescriptions, ask: is this the medication my doctor prescribed?
13. Make sure you can read the prescription label and understand the instructions and warnings. If it is a liquid, ask the pharmacist about the best device to measure the dose and make sure you know how to use it.

Discharge

14. When you or your child is being discharged, ask your or your child's doctor and nurses about the treatment plan you or your child will follow at home. Make sure you fully understand what is involved and for how long. Include questions about medications, other forms of therapy and any follow up office visits needed.

I acknowledge that I have received "A Patient Guide – Ways to Help Prevent Medical Errors."

Patient signature

Date

Guardian signature

Date

WBI staff signature

Date

Wyoming Behavioral Institute
2515 E. 15th Street
Casper, WY 82609
(307) 237-7444

Code of Conduct

Introduction

All persons entering Wyoming Behavioral Institute have the right to be safe, and feel safe. With this right comes the responsibility of being a law-abiding citizen and to be accountable for actions that put the safety of yourself and others at risk. Wyoming Behavioral Institute standards of behavior apply to each individual patient, and also include parents and guardians, visitors, therapists, physicians, nursing staff, and all other persons involved in providing your care.

Respect

Individuals are to be treated with respect and dignity. Respect and responsibility are demonstrated by:

- Following the established rules and taking responsibility for his or her own actions.
- Following the reasonable directions of persons in authority.
- Everyone is expected to use non-violent means to resolve conflict. Verbal or physically aggressive behavior is not a responsible way to interact with others.
- Being on time and ready to participate in groups and activities.
- Not using loud, offensive, vulgar language meant to demean others.
- Verbal communication is expected to be calm, polite and respectful when speaking to peers or staff.

Responsibility and participation

Active participation in treatment involves actively participating in groups, activities, and contributing to a positive community. Focusing primarily on self while being aware of the rights of others is your responsibility. This includes maintaining confidentiality of peers while residing at WBI any also after discharge. Our expectation is that clients will respond appropriately to written and verbal directions given by WBI personnel.

Vandalism

Our community is entitled to enjoy property free from the abuse of others. Vandalism is the willful marring, defacing, or destruction of property. Causing, intent to cause, or attempt to cause damage to WBI property is prohibited.

Fighting/Assault/Threats

All members of the WBI community are entitled to an environment free from threat, aggression and assault. Patient safety both emotionally and physically is of great importance.

- Cursing, threatening, using abusive language, bullying, teasing, hazing or other acts of intimidation are prohibited.
- Assault, whether intentional or unintentional, upon peers or WBI staff is prohibited.
- The willful use of physical violence, which is intended to result in bodily injury or the use of dangerous objects in effort to cause injury to oneself or others are prohibited.
- Sexual acting out, threats, intimidation or innuendo are prohibited.

By signing this, I acknowledge receipt of the document entitled "**Code of Conduct.**" I also verify that I have read, understand and agree to abide with the "new patient/new family orientation meeting this weekend at WBI and will have the opportunity to discuss with WBI staff questions I/We might have regarding the "**Code of Conduct.**" I also understand that I can assist in maintaining the hospital as a "place of healing" by providing WBI staff (RN or Therapist) with coping strategies that I/We have found to be helpful when feeling upset, anxious, angry, agitated or out of control. I understand that exhibiting destructive, volatile, aggressive behavior disrupts and jeopardizes my/our treatment.

Date _____

Patient Signature

Parent Guardian Signature

Parent Guardian Signature

Staff Witness Signature

Wyoming Behavioral Institute Educational Services

Dear Parent/Guardian,

We understand that it can be a stressful time when your child is hospitalized. To ease your concerns I would like to share some information with you about the school program at Wyoming Behavioral Institute. Below is a list of frequently asked questions about the education services at WBI and their answers.

Frequently Asked Questions about the Education Program at WBI:

Q: What happens to school when my child is admitted to WBI?

A: Once an educational release is signed a contact is made with the home school to address attendance and request homework and/or make an academic plan. This takes approximately 48 hours after admission for initial contact to be made. We will also contact the school prior to discharge to let them know the student will be return all materials this time or parents may also return material. We are available to do a re-entry meeting and discuss progress and recommendations with the school and parents.

Q: What is the difference between acute, adolescent school, children's classroom an RTP school?

A: The acute school program has one hour a day, Monday through Friday, which is dedicated to homework from the students' school. This is a maintenance program where tutors help the students with their homework. The objective is to minimize the amount of make-up the student will do upon return to their school.

The children's classroom is in session for two hours a day, Monday through Friday. We provide a basic curriculum that is focused around appropriate classroom behaviors. Students may either work on assignments provided by their home school or be placed on our curriculum. Many students do a combination of both homework and WBI curriculum.

Due to the longer length of stay, students on RTP go to school for four hours a day, Monday through Friday. WBI, the parents, and the home school, decide on an academic plan for each individual student. Typically this plan is for the student to work on curriculum provide by WBI.

Q: Can parents call and get homework or books from the school?

A: Yes! In fact this is often the best way to get the work to the student. Although WBI will contact the school to request and collect homework, it is a slower process. It can take up to 48 hours for initial contact to be made, and an additional 48 hours for the student to receive the assignments from the school. Parents who wish to speed the process are welcome to contact the school and transport assignments and books from the school to WBI. It is also extremely helpful to the process when parents sign the educational release upon admission.

Q: What should I do with school supplies?

A: Any school supplies that come into WBI need to be clearly marked with the student's name. It is also helpful to have the school's name and/or the word "school" on the school supplies. All clearly marked school supplies can be left at the nurse's station.

Q: Can students catch up on all old missed school assignments while here at WBI?

A: Unfortunately the acute program only has one hour a day to work on schoolwork. This means even when the student is working quickly and diligently during school the very most we can expect is to maintain current standings in some core classes. Realistically, the acute school is designed to minimize the amount of make up work that the student will need to do upon return to school. We value education, but we also recognize that this is a treatment facility. It is the student's first priority to work on treatment issues.

Q: Can students earn school credits while at WBI?

A: Yes, a student in our residential program can earn credit. Each student's case is reviewed on an individual basis. A curriculum in math, language arts and health is provided by certified teachers. We only provide these three courses due to the short stay in our residential program. Schools and WBI communicate and coordinate with each other about the best way to educate each student. Most students work out of WBI's curriculum. However, depending on the student's needs, the student may continue to work from their own school curriculum, as well as a combination of both their own curriculum and WBI's curriculum. Acute students do not earn credits from WBI due to the shorter length of stay.

Thank you for taking the time to read this over and please call if you have any questions or concerns.
Sincerely, Education Director Minda Smith, (307) 237-7444 ext. 267

WYOMING BEHAVIORAL INSTITUTE NOTIFICATION OF EDUCATIONAL SERVICES

NAME OF STUDENT: _____

DATE OF BIRTH: _____

ADDRESS: _____

ZIP CODE: _____

CITY: _____ STATE: _____

PHONE: _____

MOTHER'S NAME: _____

FATHER'S NAME: _____

School currently enrolled in: _____ GRADE: _____

City: _____

Date of last attendance: _____

Name of counselor/doctor seen in school: _____

Location of schoolbooks: (locker, car, home, other): _____

I AUTHORIZE THE SCHOOL DISTRICT TO RELEASE THE FOLLOWING INFORMATION TO WYOMING BEHAVIORAL INSTITUTE:

- PSYCHOLOGICAL TESTING
- TRANSCRIPTS
- IMMUNIZATION RECORDS
- I.E.P.

- I authorize WBI to contact the school to set up Homebound instruction and to arrange homework. This will include **VERBAL** exchange of information.
- I authorize WBI to arrange for staffings to take place at the school or by phone, to discuss progress and recommendations.
- I authorize the release of **WRITTEN** information from WBI, which includes the Educational Discharge (how the child progressed/behaved in school and the recommendations regarding school and education) and the Woodcock Johnson test (a general education test) and the Discharge Plan which gives: admit date; discharge date; diagnoses; outpatient appointments/followup care; medication type/dose; special instructions; risks; prognosis; physician recommendations)

I authorize Wyoming Behavioral Institute to release following documents:

- Final Discharge Summary
- Psychiatric Evaluation
- Psychological Testing

(I am aware that these documents will contain detailed, sensitive, information about my child's history; my family history and my child's treatment history)

FAILURE TO AUTHORIZE SCHOOL COMMUNICATION MAY RESULT IN WYOMING BEHAVIORAL INSTITUTE'S INABILITY TO ARRANGE FOR EDUCATION SERVICES THROUGH THE SCHOOL DISTRICT AND THE LOSS OF EDUCATIONAL CREDITS/GRADES FOR YOUR CHILD.

I UNDERSTAND THAT ANY OTHER WRITTEN INFORMATION WILL REQUIRE A SPECIFIC RELEASE OF INFORMATION TO BE SIGNED.

PARENT/GUARDIAN SIGNATURE

DATE

PATIENT SIGNATURE

DATE

WITNESS

DATE

I hereby release both the above parties from any liability which may result from furnishing the information released or

requested. This consent will expire **6 months from date of discharge**, unless revoked in writing.

**Wyoming Behavioral Institute (WBI)
Patient Bill of Rights (2007)**

A patient has the right to:

- Reasonable access to care consistent with the capacity, capability and resources of the facility regardless of the source of your payment.
- Courteous, considerate, and respectful care in a safe environment that respects your personal value and beliefs, regardless of age, gender, religion, sexual orientation, disability and if needed interpretive services.
- To be safe from physical, sexual and mental abuse.
- Consideration of your mental, emotional, social, spiritual, and cultural needs and the opportunity for religious worship.
- Take part in decisions about your healthcare. You or your designated decision-maker will be included in the planning or care and to be able to express your treatment preferences. This will allow you to well informed so you can assist in your own treatment.

This right includes the following:

- Have your pain assessed and managed. Your pain should be at a minimum level. You should be able to take part in work and recreation. You should be able to sleep at night.
- To accept or refuse healthcare treatment to the extent permitted by law, and be informed of the consequences of refusal.
- Ask for information, including being informed of possible unexpected outcomes and risks of treatment or medications, to help you make healthcare treatment decision consistent with your wishes.
- Express a complaint about quality of care, staff, premature discharge or coverage decisions, and receive prompt attention to your concerns. These complaints may be made to the Chief Executive Officer or the Grievance Coordinator.
- Refuse to participate in research projects.
- Maximum possible privacy. Rooms will be assigned based on census, patient needs and compatibility.
- To have all medical and personal information treated as confidential unless you consent to its release or its disclosure is required or permitted by law.
- Be free of seclusion or restraints unless clinically indicated.
- Communicate with persons outside of Wyoming Behavioral Institute.
- Receive or refuse visitors.
- Receive unopened mail. You will be required to open the mail in the presence of staff.
- Write and send letters. You may request assistance if needed.
- Wear your own clothes. Keep personal belongings, in accordance to policy of the program.
- Keep and spend your own money, in accordance to the policy of the program.

A Patient (along with their family) has the responsibility to/for:

- Be considerate of the rights and property of other patients and property of other and or WBI staff.
- Provide WBI with the patient's complete health history and to tell staff if they are feeling ill or developing new symptoms.
- Follow the treatment plan developed for their care and communication to staff if they do not understand the treatment plan and what is expected of them.
- Abiding by the rules and regulations of WBI and the treatment program in which they are enrolled.
- Not interfere with the treatment of other patients or WBI staff in the treatment of other patients.
- Maintain the confidential nature of their clinical information and records and to maintain the confidentiality of other patients and their records.
- Maintaining the personal property that they are allowed to keep in their possession. WBI assumes no responsibility for lost or stolen personal property.

IN THE EVENT THAT I EXPERIENCE A MEDICAL CRISIS, I UNDERSTAND ARRANGEMENTS WILL BE MADE TO TRANSPORT ME TO THE EMERGENCY ROOM OF WYOMING MEDICAL CENTER FOR CARE.

I have received a copy of and understand my rights and responsibilities as a patient at Wyoming Behavioral Institute.

Patient Signature

Date

Guardian (if Applicable):

Date

Witness:

Date

**WYOMING BEHAVIORAL INSTITUTE
2521 EAST 15TH STREET
CASPER, WY 82609
(307) 237-7444**

**GRIEVANCE PROCEDURE
Patient/Parent/Family**

Wyoming Behavioral Institute offers patients a process through which they may file a complaint, or "Grievance" if concerned about their care, the staff, or any hospital issues. Any patient who believes his/her rights have been violated is entitled to access this process. Wyoming Behavioral Institute designates a "Grievance Coordinator" who is responsible for reviewing any and all complaints received from patients. Your concerns are important to us as we strive to provide you with the best possible services possible.

If you or your family member have a complaint the following procedure is outlined to assist in resolution of that complaint.

Step 1. The patient/family/guardian will first bring his/her complaint to the staff with whom they have the complaint for private discussion. The staff will discuss the complaint with the patient/family/guardian and raise any questions that need attention. Every effort will be made to resolve the problem in this first step.

Step 2. If no resolution is reached in Step 1, the patient/family/guardian will be asked to request a "grievance form" and state their complaint/grievance in writing. This written grievance form may be given to any staff member who will place the form in the unit "grievance box." Hospital management retrieves items from this box daily Monday through Friday excluding holidays. If you have a complaint on a weekend or a holiday and wish to speak to someone in authority, you may request to see the supervisor on duty or on call. Management will assure that our designated grievance coordinator receives your written grievance. The coordinator (designee) will set up a meeting with you and others involved to discuss your grievance and attempt to resolve the issues. If the parties agree the issue is resolved, the patient/family/guardian will be asked to sign the form and it will be sent to the WBI Performance Improvement Coordinator for tracking. The written grievance form will be responded to and interviews completed with a documented outcome within 10 business days from date of receipt by the grievance coordinator. If the matter cannot be resolved at this point, the grievance procedure moves to Step 3.

Step 3. A meeting will be arranged with the WBI Chief Executive Officer (CEO) and any other appropriate people as requested by any of the parties involved. Within 5 business days after this meeting, a written response will be sent to all parties. A copy will also be forwarded to the WBI Performance Improvement Coordinator for filing.

If a patient/family/guardian is not satisfied with the outcome from this complaint/grievance process they may contact the listed state agencies for further review or the Joint Commission on Accreditation of Healthcare Organizations.

**Office of Health Licensing and
Surveys (State Agency)
400 Qwest Building
6101 North Yellowstone Road
Cheyenne, WY 82002
307-777-7123**

**Mountain-Pacific Quality Health
Foundation
2206 Dell Range Blvd., Suite G
Cheyenne, Wyoming 82009
(307) 637-8162 or (877) 810-6248
1-800-497-8232**

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CUSTODY DISCLOSURE

Dear parent/guardian,

In an effort to provide your child with the best care and re-integrate the child back into your loving family, we need to know the legal standing of custody.

We are asking you to provide Wyoming Behavioral Institute with a legible copy of the custody papers on your child. We ask to receive this copy within 3 working days.

Due to Wyoming State Statute, 20-2-201 (e) Wyoming Behavioral Institute is not able to restrict a non-custodial parent access to or information on a child without the custody papers.

| | |
|--|-----------|
| ARTICLE 2 - CUSTODY AND VISITATION | 20-2-201. |
| (e) Unless otherwise ordered by the court, the noncustodial parent shall have the same right of access as the parent awarded custody, to any records relating to the child of the parties, including school records, activities, teachers and teachers' conferences as well as medical and dental treatment providers and mental health records. | |

Custody papers are not available because (to be completed by parent/guardian): _____

PATIENT NAME (please print)

SIGNATURE OF LEGAL GUARDIAN
(FOR MINOR OR INCOMPETENT PERSON)

DATE

WYOMING BEHAVIORAL INSTITUTE STAFF

DATE

**WYOMING BEHAVIORAL INSTITUTE
2521 E. 15TH STREET
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Protected Health Information

Respecting Your Privacy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected Health Information

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state laws to protect the privacy of your health information. We call it Protected Health Information (PHI).

Staff members, employees and volunteers of this hospital/facility must follow legal regulations with respect to:

- How we use your PHI
- Disclosing your PHI to others
- Your privacy rights
- Our privacy duties
- Hospital contacts for more information nor if necessary, a complaint

Using or disclosing your PHI:

For treatment

During the course of your treatment, we use and disclose your PHI, for example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x ray, surgical procedure or other types of treatment related procedures.

For payment

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

For healthcare operations

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital and resolution of a complaint.

Special uses

Your relationship to us as a patient might require using or disclosing your PHI in order to:

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

Your authorization may be required

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment

or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. You may revoke your authorization if you change your mind later.

Certain uses and disclosures of your PHI required or permitted by law

At a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

Required or permitted uses and disclosures

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

We may also use or disclose your PHI:

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reactions to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a workers compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclose will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

Your privacy rights and how to exercise them

Under the federally required privacy program, patients have specific rights.

Your right to request limited use or disclosure

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

Your right to confidential communication

You have the right to receive confidential communication from the hospital at a location you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

Your right to revoke your authorization

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

Your right to inspect and copy

You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

Your right to amend your PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made a part of our record about you.

Your right to know how else we see your PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

What if I have a complaint?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with the facility or the Secretary.

- To file a complaint with us, please contact the hospital's Risk Management Department or call the UHS Compliance Hotline at 1-800-852-3449. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C. 20201 or call 1-877-696-6775.

Some of our privacy obligations and how we fulfill them

Federal health information privacy rules require us to give you notice of our privacy practices. This document is our notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law.

If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

Compliance with certain state laws

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective date: This notice takes effect on April 14, 2003

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Manual Privacy Practices Procedure – BH

Receipt of Privacy Practices

- Over 18 years of age
- Under 18 years of age
- Emancipated minor child
- Over 18 but still dependent

Acknowledgement

I acknowledge that I have received the Hospital's Notice of Privacy Practices.

Patient's Signature

Date

Patient's authorized representative signature

Relationship to patient

Date

Witness signature

Witness job title

Patient is unable to sign this receipt because _____

Patient has requested no exceptions to the use or disclosure of PHI at this time.

Intake/Admissions Staff: Attach original to patient's chart.

**UPLIFT
AUTHORIZATION FOR
MUTUAL EXCHANGE OF
CONFIDENTIAL INFORMATION**

Student Name: _____ **Date of Birth:** _____

AS PARENT/GUARDIAN OF THE ABOVE CHILD, I HEREBY REQUEST THE RELEASE OF CONFIDENTIAL INFORMATION (Including Educational Plans, Assessment Result, Medical Findings, Developmental, Health and Immunization History, Legal Proceedings and /or Relevant Data) **FROM THE FOLLOWING AGENCIES:**

All Related Agencies

Name of Agencies (Addresses, Phone Numbers if needed):

For the purpose of exchanging information on the above child in an effort to provide the most appropriate services to meet the needs of the child.

I AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION TO BE GIVEN TO THE ORGANIZATION LISTED BELOW

| | | |
|--|--|---|
| <p>UPLIFT – Buffalo 830 West Fetterman St. Mailing: P.O. Box 566 Buffalo, WY 82834 Office: 307-684-7813 Fax: 307-684-7818</p> | <p>UPLIFT – Casper 145 S. Durbin St. Suite 201 Casper, WY 82601 Office: 307-232-8944 Fax: 307-232-8945</p> | <p>UPLIFT – Cheyenne 4007 Greenway St. Suite 201 Cheyenne, WY 82001 Office: 307-778-8686 Fax: 307-778-8681</p> |
| <p>UPLIFT – Jackson 530 Elk Ave. Suite 3 Mailing: P.O. Box 986 Jackson, WY 83001 Office: 307-734-1327 Fax: 307-734-2561</p> | <p>UPLIFT – Riverton 877 N. 8th St. W. Suite 1 Riverton, WY 82501 Office: 307-857-6601 Fax: 307-857-4446</p> | |

www.upliftwy.org

Parent/Guardian Signature
Date

Address

City, State, Zip

Phone