WYOMING BEHAVIORAL INSTITUTE

PATIENT INFORMATION FORM

CIRCLE ONE

CHILD ADOL
ADULT GERO
PSYCH CD RTP

ADMIT DATE:_________________
ADMIT TIME:_________________

Primary Insurance
Name of Insurance:______________________________
Name of Guarantor:______________________________
Guarantor SS#:__________________________________

Secondary Insurance
Name of Insurance:______________________________
Name of Guarantor #:____________________________
Guarantor SS # _________________________________

PATIENT INFORMATION:

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

LEGAL GUARDIAN:____
NAME **RELATIONSHIP**

ADDRESS:____
MAILING ADDRESS (if different):____

Have you ever been a patient under any other name? What name?________________

____
City State ZIP County

( )____
HOME PHONE SOCIAL SECURITY NUMBER

AGE:______ DATE OF BIRTH________ SEX: **M** **F** RACE:__________ Religion:____________
MARTIAL STATUS:__________________________
PATIENT EMPLOYER:________________________________Work phone:____________
ADDRESS:____ Status: full part
FAMILY PHYSICIAN:________________________________City__________________
Guarantor:_______________________________________Guarantor SS#___________________________

Preferred language
____
Interpreter needed
Yes ___No____

LEGAL GUARDIAN:

NAME:____ Relationship:________________
ADDRESS:____ HOME Phone:________________
Mailing address if different:_________________________ WORK Phone:________________
EMPLOYER:____ Status: full part
ADDRESS:____
E-MAIL ADDRESS: ____

EMERGENCY CONTACT (Next of Kin)

Name:
Relationship:
Address:
City State Zip
Home phone
Work phone

Nearest Relative not living with you

Name:
Relationship:
Address:
City State Zip
Home Phone:
Work Phone:

PHYSICIANS:
Admitting:_________________________

LEGAL STATUS: (circle one)
INVOLUNTARY VOLUNTARY
REFERRAL SOURCE:___________________________

SIGNATURE OF PATIENT/GUARDIAN:____________________________________DATE:____________

WYOMING BEHAVIORAL INSTITUTE STAFF:_____________________________DATE:___________

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.

4. PERSONAL VALUABLES: I understand that the hospital maintains a safe for the safekeeping of money and valuables of small size. The hospital shall not be liable for the loss or damage of any money or personal property.
WE STRONGLY RECOMMEND THAT ANY BELONGINGS OF MONETARY VALUE OR SENTIMENTAL VALUE BE SENT HOME, AS WE WILL NOT BE RESPONSIBLE FOR THE LOSS OF THESE ITEMS.

5. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I, the undersigned agree, whether signing as agent or patient, that in consideration of the admission of the patient in this hospital, and for services to be rendered to the patient, I hereby authorize payment directly to WYOMING BEHAVIORAL INSITUTE AND THE ABOVE-NAMED PHYSICIAN(S) of the hospital/physician(s) benefits and/or major medical benefits otherwise payable to me for the hospitalization of the patient. I understand that I am financially responsible to the hospital and physician(s) for all charges not covered by this assignment, and hereby assume full responsibility for the payments. Should the account be referred to an outside collection agency or attorney for collection, I shall pay reasonable attorney's fees, interest, and collection expenses allowable by law.

6. CONSENT TO SEARCH: To ensure my safety and the safety of all other patients and staff, I understand upon admission a member of the hospital staff will search my clothing, belongings, and person. During hospitalization, random searches may occur if a question of safety arises. Any weapons brought into Wyoming Behavioral Institute will be confiscated and sent home with family/friends or will be turned over to Casper Police Department.

7. EXPLANATION OF CHARGES: The estimated amount quoted for hospitalization is for HOSPITAL CHARGES ONLY. The benefits quoted by your insurance carrier and relayed to the Business Office is only an ESTIMATE and NOT a guarantee of payment, and it is not intended to be a final statement of financial responsibility. It is our recommendation that you check with your insurance company or your policy to determine and understand your coverage. Although we will pre-certify your admission, the primary responsibility is YOURS.

8. PHOTOGRAPHS: I consent to have my photograph taken as means of identification and understand that these photographs will become part of my medical records. Camera monitoring is used throughout the facility for safety.

9. ***FORMAL VOLUNTARY ADMISSION:*** I, the undersigned, hereby request admission to Wyoming Behavioral Institute and agree to abide by the rules and regulations of the facility. I have been informed that if I desire to be discharged, ***I shall provide twenty-four (24) hours written notice*** to the program director. (W.S. 10-108)

10. **MINOR PATIENTS:** If the records are regarding someone under the age of 18 who has had drug and/or alcohol diagnosis, treatment or education, Federal Regulations require us to obtain the signature of the minor too. Per Wyoming Statutes, a non-custodial parent has the same right to information on a minor as a custodial parent.

11. PATIENT RIGHTS: The undersigned acknowledges that a copy of the patient rights has been given to them and that these rights have been explained, and that they understand these rights.

12. ADVANCE DIRECTIVES: The undersigned acknowledges that he/she has been given written material about his/her right to accept or refuse medical and mental health treatments, been informed of his/her rights to formulate Advance Directives, understands that he/she is not required to have an Advance Directive in order to receive medical and mental health treatment at this health care facility, and further understands that if he/she has executed Advance Directives (and have given WBI a legible copy of it) it will be followed by the health care facility and my caregivers to the extent permitted by law.

__________ I HAVE been given written material __________ The patient is a MINOR (no information needed)

PATIENT NAME (please print) PATIENT SIGNATURE DATE

SIGNATURE OF LEGAL GUARDIAN (FOR MINOR OR INCOMPETENT PERSON) DATE SIGNATURE OF INSURED/GUARANTOR DATE

WYOMING BEHAVIORAL INSTITUTE STAFF DATE

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: ____

____

____

RELATIONSHIP TO PATIENT:__________________________________

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

INFORMATION (INITIAL) **(INITIAL)**
I authorize the following information to be released/requested:

____ DISCHARGE SUMMARY
____ PSYCHIATRIC EVALUATION
____ HISTORY/PHYSICAL EXAM
____ LABS/X-RAY/EKG/MRI/EEG (including HIV/AIDS)
____ CONSULTATIONS
____ PHYSICIAN OUTPT NOTES
____ PSYCHOLOGICAL TESTING
____ MEDICATION INFORMATION
____ TREATMENT PLAN
____ EDUCATIONAL EVALUATIONS
____ VERBAL COMMUNICATIONS
____ 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 form 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 AND/OR THE STATUS OF CONDITION.**

Please **x** for Approval

Date Added	Date Deleted	PERSON/FAMILY MEMBER NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT	PHONE CALLS **x**	VISITS **x**	**AUTHORIZED BY**

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
CONTACT FORM

WYOMING BEHAVIORAL INSTITUTE
2521 East Fifteenth Street
Casper, Wyoming 82609
307-237-7444

I, the undersigned, understand that Wyoming Behavioral Institute has entered into agreements with several institutions of teaching to provide students with exposure and limited experience in the Mental Health and/or Behavioral Health field.

Following are the types of students recognized by Wyoming Behavioral Institute

A. NURSES (RN)
B. OCCUPATIONAL THERAPISTS
C. BSW
D. PSYCHOLOGIST CANDIDATES
E. PHYSICIAN ASSISTANTS (PA)
F. RESIDENT PHYSICIANS
G. MEDICAL STUDENTS
H. TRANSCRIPTIONISTS
I. MASTER LEVEL CANDIDATES

I give permission for these recognized students to have access to myself and to my records for the sole purpose of education.

______________________________ __________
Signature of Patient Date

______________________________ __________
Signature of Parent/Guardian Date

______________________________ __________
Witness Date

PATIENT/FAMILY EDUCATION AND NOTIFICATION REGARDING THE USE OF SECLUSION AND RESTRAINT

Seclusion and Restraint are a last resort method used to help a person regain control in the event than an emergency occurs and the person is in serious danger of harming him/herself or others.

- Seclusion is the confinement of a person in a locked room.
- Restraint is the use of physical force to a person to restrict his or her freedom of movement. The physical force may be staff, mechanical devices such as straps, or a combination of these.

Before seclusion or restraints are used, every method available will be used to help a person gain control. These measures include:

- Verbal one-to-one therapeutic conversations to de-escalate
- Grounding techniques
- Relaxation techniques
- Allowing a person to have quiet time
- Removal from the situation; time out
- Medications
- Diversional activities
- Attending group
- Calling your therapist or doctor
- Other techniques that have worked for the person in the past

Each adult person has the right to have their family or significant other notified if seclusion or restraint are utilized. Parents and guardians of minors (17 year old and younger) will be notified unless the minor is emancipated. In the case of an emancipated minor, guidelines for adults will be following.

I have read and understand the above information.

FOR ADULT PATIENTS ONLY

I, (Patient)__________________________( ) do ( ) do not want to have a family member notified if seclusion or restraint are utilized. Please name the family member you would like notified (if applicable):

Name:____Relation:_____________________

Telephone number:______________________________________

Patient signature:________________________________Date:___________________________________

Family member:______________________________ __ Date:___________________________________

Staff Witness:__________________________________ Date:___________________________________

WYOMING BEHAVIORAL INSTITUTE
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 job 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 feeing 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 form 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

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

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
CASPER, WY 82609
(307) 237-7444

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 year 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 pro9tect 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 discloser 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 that the right and 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 he amendment and you 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 sees 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 ahs 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 thee 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 no 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

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

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

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

www.upliftwy.org

____

Parent/Guardian Signature
Date

____

Address

____

City, State, Zip

____

Phone