SUNBURST MENTAL HEALTH SERVICES
PARTICPANT INTRODUCTION TO SERVICES

Welcome to Sunburst Mental Health Center. It is our privilege to be assistance to you. Our vision is to create communities in which children and adults are safer, more secure and are supported. We believe that when a hand reaches out in need, it should be met with another.

Sunburst Mental Health offers a variety of services including outpatient therapy, medication management, intensive service coordination, community based rehabilitation and support, chemical dependency services, and crisis telephone services. You may participate in one or more of these services with Sunburst and a list of other service providers in the area will be provided to you. If you are working with other mental health providers, we will do our best to integrate services with them.

What you should expect from Sunburst Mental Health services:

- To be treated with respect and have staff value your relationships with others
- To be seen as the expert about you
- To have a voice and choice in services that you participate in with Sunburst
- To set your own individualized goals
- To have respect for your particular culture and to have services be culturally sensitive
- To have a team that is focused on maintaining children and adults in their homes, with their families
- To have integration in the services that you receive
- To be educated about your diagnosis and learn about different treatment options
- To receive treatment from staff who are competent, caring and compassionate
- To have staff provide services with strength-based thinking
- To have services focus on recovery, as defined by you and your family
- To have services that you choose to participate in, available throughout the year.

Crisis Care:

Sunburst staff will work hard to help you prevent a crisis, or quickly resolve one when it occurs. When you need to contact someone in a crisis situation, call Sunburst Mental Health Services during working hours and (406) 756-2968 after hours.

NOTICE TO SUNBURST PARTICIPANTS:

In an effort to reduce no-shows and same day cancellations and improve access to our providers the following policy is in place as of April 2, 2018:

At Sunburst, a 'no show' is defined as: Any same day missed appointment, such as not showing up for a scheduled appointment with no notice, OR calling and cancelling a scheduled appointment without providing 24 hour notice.

For Intake Appointments:

- If you miss an intake appointment you will be rescheduled one more time for a med appointment, and have two more chances for a therapy appointment.
- If you miss a second (or third for therapy) intake appointment you will be referred to another community provider.

For Scheduled Follow Up Appointments:

A. If you miss your scheduled appointment without a valid excuse you will be placed on the NO SHOW LIST (see Exceptions)

B. Any person on the NO SHOW LIST who fails to show up for their scheduled appointment during the 3 month period since being placed on the NO SHOW LIST will not receive any further scheduled appointments

C. Any person in category B above in order to be seen by a therapist or meds provider must show up
on the day and time providers have set aside to see such persons and will be seen provided the provider has an opening. No appointments will be made for you if you are in this category.

D. You may request that you be taken off the NO SHOW LIST if 3 months have gone by since your last no show/cancellation

E. If you are in Category B then for MED appointments you will only receive enough refills to allow you to make it to the day for which you hope to see a provider. Should you fail to show up on this day you possibly may not receive ANY MORE REFILLS UNTIL YOU ACTUALLY MEET WITH THE MEDS PROVIDER.

Exceptions: If an appointment is cancelled with as much notice as possible as a result of major crisis, severe psychiatric symptoms, or medical illness, it will be up to the discretion of the Program Supervisors or Site Managers whether or not to implement the above policy in such cases.

Thank you for choosing Sunburst!

SUNBURST MENTAL HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. We are reserve the right to change the terms of our Notice of Privacy at any time. Any new Notice of Privacy Practices will not be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing you one at your next appointment.

How We May Use and Disclose Health Information About You

For Treatment: Your PHI may be used and disclosed by those who are providing services for the purpose of providing, coordination, or managing your services. This includes consultation with clinical supervisors or other Sunburst Staff team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may not use and disclose PHI so that we can receive payment for the services provided to you. This will only be done with your authorization. Examples of payment-related activities are making a determination of eligibility for Targeted Case Management, processing claims with Targeted Case Management. Reviewing services provided to you with DPHHS, or undertaking utilization of review activities.

For Services Operations: We may use or disclose, as needed, your PHI in order to coordinate services. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be used to remind you of your appointments via mail, or recorded answering machine messages. A review of services between DPHHS and Sunburst will occur during review of services provided during staff meetings, formal and informal. State Mental Health Services and Licensing have access to records to insure qualify of care and services rendered.

Required by Law: Under the law, we must make disclosers of your PHI to you upon your request. In addition, we must make disclosers to the Secretary of the DPHSS for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigation (such as social work licensing board or the health department).

- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen the threat, including the target of threat.

The following is the categories of uses and disclosers permitted by HIPPA without authorization: abuse and neglect, judicial and administrative proceedings, deceased persons, emergencies, family involvement in care, health oversight, law enforcement, national security, public health, and public safety (duty of warn)

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

- **Right to Access to Inspect and Copy-** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right too inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. All records of services that are DPHHS funded are property of DPHHS-CFS Division. Request for records will be directed to DPHHS-CFS division.
- **Right to Amend-** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting Disclosures-** You have the right to request an accounting of certain disclosures that we make of your PHI.
- **Right to Request Restrictions-** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication-** You have the right to request that we communicate with you about medical matters in certain way or at a certain location.
- **Right to a Copy of this Notice-** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights you that the right to file a complaint in writing with our Privacy Officer, Julie Fleck at (406) 885-4074 or with the Secretary of Ehalth and Human Services at 200 Independence Avenue, S.W. Washington, and D.C. 20201 or by calling (202) 619-0257

Grievance Procedure

Sunburst Mental health has established a grievance procedure and if you are dissatisfied with any action regarding services you may request a review of all actions taking in your case. If you feel your rights have been violated, please see any staff member to request the Grievance procedure.

SUNBURST MENTAL HEALTH SERVICES
PARTICPANT RESPONSIBLITIES

Sunburst Mental Health has provided you with information about your rights and how to protect those rights. Your responsibilities as a Sunburst participant are as follows:

- Be respectful of staff and other sunburst participants
- Show up for your appointments and when you cannot, let us know ahead of time
- Use polite language with Sunburst staff
- Work out safety plan with your treatment team to prevent crisis
- Call us when you need help don't call us after hours to chat or touch base
- If you are feeling like doing self-harm or harm to others, contact Sunburst Staff
- Tell us what you want in services and what you do not want
- Be confidential about other Sunburst participants you may see in the agency
- Smoke is prohibited inside the office
- When we visit your home, please have other guests leave
- When we visit your home, please do not smoke
- Tell us how we can assist you better

Conduct that will result in suspension or termination of services:

- Bringing a weapon into Sunburst facility
- Having a weapon in sight during a home visit
- You or someone close to you having threatening behavior towards a Sunburst employee
- You or someone close to you physically harming a Sunburst employee
- Bringing a lawsuit against Sunburst and/or employee

If this occurs you will:

- Receive written notification describing why you are not eligible for services for a period of time, or indefinitely. You will receive a list of agenies who provide similar services.
- To be eligible for re-instatment of services, you will:
    1. Need to meet with MHC Administrator and discuss the situation that occurred, take responsibility for your actions, apologize to the parties involved and if needed, make restitution for any physical damages.
    2. Have a plan to prevent such occurrences in the future

Sunburst reserves the right to suspend and discontinue services based upon participant conduct that endangers others. Depending upon the situation, reinstatement may occur.

If you do not agree with decisions made about suspension or disconsolation of services.

You may submit a written appeal following the Sunburst Participant Grievance Procedure. If you have not already been given a copy of this, please ask for one.

SUNBURST MENTAL HEALTH SERVICES
PARTICPANT FEE PAYMENTS AND BILLING

Fee Payments and Billing:

Sunburst Mental Health fees include routine reports and submission of insurance claims. We will need to bill for any exra-long or complex reports that are required.

You are responsible for paying the fees we agree upon. If you ask us to bill and insurance company or any other person or agency, and we do not receive payment on time, we will then expect this payment from you.

If there are any problems with the charges, billing , your insurance or any other money related matters, please bring it to our attention. We will do the same with you. Because these problems can interfere with our work together, they must work out openly and quickly.

SUNBURST MENTAL HEALTH SERVICES
INTAKE ACKNOWLEDGMENT

Participant's Name: _____

I hereby acknowledge that I have reviewed or received the following information by initialing and dating the items:

At Reception:

		Initial	Date
1.	Consent to Bill Insurance and Fee Agreement	_____	_____
2.	Notice of Privacy Practices (HIPPA)	_____	_____
3.	Participant Grievance Procedure	_____	_____
4.	Participant Responsibilities	_____	_____
5.	Health Screening Form	_____	_____
6.	Policy on Visit Cancellations	_____	_____
7.	After Hours Crisis Line Information	_____	_____

At Intake:

		Initial	Date
1.	Introduction to Services & Confidentiality	_____	_____
2.	Potential Risks and Benefits of Therapy	_____	_____

Signature: _____ Date: _____
Participant or Legal Representative

Signature: _____ Date: _____
Sunburst Mental Health Representative

SUNBURST MENTAL HEALTH SERVICES
CHECKLIST OF CONCERNS

Please rate the following concerns according to the following.

(Leave the space blank indicates the issue is not a problem for you, whereas each problem issue is to be assigned a 1, 2 or 3.)

1. – Sometimes a problem 2. – Frequently a problem 3. – Most all the time a problem

_____ Feeling out of control	_____ Sleepwalking	_____ Thoughts that others want to hurt me
_____ Easily hurt feelings	_____ Taking unnecessary risks	_____ Sees things that others do not see
_____ Frightening Thoughts	_____ Repetitive thoughts	_____ Needing a philosophy of life
_____ Unhappiness	_____ Weight Problems	_____ Feeling life is not worthwhile
_____ Disturbing Grief	_____ Excessive Worry	_____ Drug Use
_____ Afraid to leave house	_____ Irritable	_____ Alcohol Use
_____ Restlessness	_____ Loneliness	_____ Financial problems
_____ Emotional highs	_____ Feeling Numb	_____ Confused as to what I really want
_____ Lost or Adrift	_____ Feeling Helpless	_____ Bad Temper
_____ Feeling Shame	_____ Sexual Problems	_____ Not knowing what kind of person I want to be
_____ Overwhelmed by Stress	_____ Depression	_____ Feelings of inferiority
_____ Hopelessness	_____ Problems at work	_____ Not smart enough
_____ To easily influenced	_____ Feeling disconnected	_____ Confused in my religious beliefs
_____ Feeling misunderstood	_____ Bitterness	_____ Physically unattractive
_____ Pessimism	_____ No sense of direction	_____ Difficulty with decisions
_____ Self-disgust	_____ Trouble concentrating	_____ Feel Unloved
_____ Self-centered	_____ Headaches	_____ Ashamed
_____ Sleep Problems	_____ Thoughts of death	_____ Memory loss/gaps
_____ Excessive pain	_____ Violent Thoughts	_____ Not ambitious
_____ Jaw tension	_____ Feeling trapped	_____ Sense of others watching me
_____ Chest pain	_____ Nervousness	_____ Dizziness
_____ Anger	_____ Hearing voices	_____ Heart pounds and races
_____ Crying spells	_____ Legal problems	_____ Trouble catching breath
_____ Guilt	_____ Eating problems	_____ Uncomfortable with people
_____ Panic	_____ Skin Problems	_____ Suicidal thoughts
_____ Easily bored	_____ Difficulty with women	_____ Difficulty with men
_____ Tiredness/Fatigue	_____ Stomach Aches	_____ Back or neck pain
_____ Fearful	_____ Difficulty trusting	_____ Peculiar sensations
_____ Nightmares	_____ Gambling	_____ Bowel disturbances
_____ Without pleasure	_____ Unwelcome habits	_____ Tremors
_____ Self-blame	_____ Feel strange or odd	_____ Hurting oneself
_____ Feel worthless	_____ High Blood Pressure	_____ OTHER _____

SUNBURST MENTAL HEALTH SERVICES
PARTICIPANT CONFIDENTIAL INFORMATION FORM

(Please note that the information requested on this form is confidential. However, you may choose to omit any item and discuss it in person.)

Today's Date: _____

IDENTIFICATION

Participant Name: _____ Social Security #: _____

Date Of Birth: _____ Age: Gender: ☐ F ☐ M Marital Status:

Parent/Legal Representative (if a minor): _____

Mailing Address: _____

Street City State Zip Code

Physical Address: _____

Street City State Zip Code

Home Phone: _____ May I contact you at home? ☐ Yes ☐ No

Cell Phone: _____ May I contact you on your cell phone? ☐ Yes ☐ No

Are you presently employed? ☐ Yes ☐ No

IF YES:

Employer: _____ Hrs./Wk. _____

Occupation: _____ How long at job? _____

Work Phone: _____ May I contact you at work? ☐ Yes ☐ No

INSURANCE INFORMATION

If insurance reimburses you for mental health services please provide the following information, **AND** a copy of your insurance card:

Insurance Company: _____ Phone: _____

Mailing Address: _____

Street / P.O. Box City State Zip Code

Subscriber's Name: _____

Policy #: _____ Group Number #: _____

REFERRAL

Who gave you our organization's name to call?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

YOUR MEDICAL CARE

From whom or where do you get your medical care? _____

Phone: _____ Fax: _____

Mailing Address: _____

Street / P.O. Box City State Zip Code

From whom or where do you get your dental care? _____

Phone: _____ Fax: _____

Mailing Address: _____

Street / P.O. Box City State Zip Code

PREVIOUS MENTAL HEALTH SERVICES

Have you received Mental Health Services before? ☐ Yes ☐ No
If yes, from where?: **(If you need more space, please continue on the next page)**

Organization's Name: _____

Address: _____

Street / P.O. Box City State Zip Code

From: _____ To: _____

Organization's Name: _____

Address: _____

Street / P.O. Box City State Zip Code

From: _____ To: _____

Have you been in an inpatient facility? ☐ Yes ☐ No
If yes, from where?: **(If you need more space, please continue on the next page)**

Organization's Name: _____

Address: _____

Street / P.O. Box City State Zip Code

From: _____ To: _____

Organization's Name: _____

Address: _____

Street / P.O. Box City State Zip Code

From: _____ To: _____

Signature: _____ Date: _____

Participant or Legal Representative

Signature: _____ Date: _____

Sunburst Mental Health Representative

SUNBURST MENTAL HEALTH SERVICES
PARTICPANT AGREEMENT FORM

Our Agreement:

I, the participant (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement. It does not indicate that I am waiving any of my rights.

I understand that I can choose to discuss any concerns with my service coordinator (case manager) or therapist before I start (or the consumer starts) services. I understand that any of the points mentioned above can be discussed and may be open to change.

I understand that after services begin I have the right to withdraw my consent to services at any time, for any reason. I will make every effort to discuss my concerns about progress with you before ending services.

I understand that no specific promises have been made to me by this worker about the results of treatment, the effectiveness of the procedures used, or the number of sessions or length of time that we will work together to achieve results.

I have read, or have had read to me, the issues and points in this introduction. I have discussed those points I did not understand and have had my questions, if any, fully answered. I agree to act according to the points in this introduction. I hereby agree to enter into services with Sunburst Mental Health (or to have the participant enter services), and to cooperate fully and to the best of my ability, as shown by my signature here.

I hereby give permission to Sunburst Mental Health for med evaluation and med management.

Signature: _____ Date: _____
Participant or Legal Representative

Printed Name: _____
Participant or Legal Representative

Relationship to consumer:

☐ Self ☐ Parent ☐ Legal Guardian ☐ Other person authorized to act on behalf of the consumer

I, the Sunburst Mental Health Worker, have met with this participant (and or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this document. I have responded to all of his or her questions. I believe that this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into services with this participant, as shown by my signature here.

Signature: _____ Date: _____
Sunburst Mental Health Representative

☐ **Copy accepted by participant** ☐ **Copy kept by Mental Health Representative**

SUNBURST MENTAL HEALTH SERVICES
PARTICPANT EMERGENCY CONTACT FORM

If I Need To Contact Someone About You:

If there is an emergency during our work together or if we become concerned about your personal safety, we are required to contact a person of your choosing and/or the authorities. We are also required to contact this person and/or the authorities if we become concerned about you harming someone else. Please write down the name and information of your chosen contact person in the blanks below.

Name: _____

Phone Number: _____

Address: _____
Street Number/P.O. Box City State Zip Code

Relationship to you: _____

If you are receiving therapy services, please review the "Potential Risks and Benefits of Therapy

SUNBURST MENTAL HEALTH SERVICES
HEALTH AND MEDICAL HISTORY

Today's Date: _____

Participant's Name: _____ Date of Birth: _____

Primary Health Care Provider: _____ Phone: _____

Have you been diagnosed with diabetes?	☐ Yes	☐ No	If so, are you insulin dependent?		
Have you had a history of head injuries?	☐ Yes	☐ No	If so, how many and when?		
Do you have high blood pressure?	☐ Yes	☐ No			
Have you had your thyroid checked?	☐ Yes	☐ No	If so, when?		
Do you have thyroid problems?	☐ Yes	☐ No	If so, please describe:		
Have you had a history of Heart problems?	☐ Yes	☐ No	If so, please describe:		
Have you had a history of lung disease?	☐ Yes	☐ No	If so, please describe:		
Do you have a history of seizures?	☐ Yes	☐ No	If so, please describe:		
Could you be pregnant at this time?	☐ Yes	☐ No	If so, how many weeks? Due Date?		
Are you allergic to any medications?	☐ Yes	☐ No	If so, please describe:		

Any other physical health concerns: _____

_____

Please tell us the approximate date of last health exam and or physical: _____

Last Dental Exam: _____ Last Eye Exam: _____

Signature: _____ Date: _____

Participant or Legal Representative

SUNBURST MENTAL HEALTH SERVICES
FEE SCHEDULE & CONSENT TO BILL INSURANCE

Medication Management Evaluation	**$**	**350.00**	
Medication Management Monitoring	**$**	**120.00**	**per 15 minutes**
Therapy Intake Evaluation	**$**	**325.00**	
Therapy	**$**	**220.00**	**per 60 minutes**
Therapy	**$**	**140.00**	**per 45 minutes**
Therapy	**$**	**110.00**	**per 30 minutes**
Service Coordination (Case Management)	**$**	**80.00**	**per hour**

I _____ hereby give my permission to Sunburst Mental Health to bill my insurance and to receive payment directly from my insurance(s). I also give permission to Sunburst Mental Health to release any and all information necessary to submit claims and receive insurance payments.

It is understand that any amount not paid by my insurance, is my sole responsibility and I agree to submit payment to Sunburst Mental Health within 30 days from the date billed.

_____ _____

Participant or Responsible Party **Date**

Authorization
Contact by Telephone/Verbally in Event of Breach of PHI

I, _____ [Insert Name of Participant], authorize **Sunburst Mental Health Services** to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI). Such conversation shall be documented by **Sunburst Mental Health Services**.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of [Insert Name of Social Work Organization].

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

SUNBURST MENTAL HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES
RECIPT AND ACKNOWLEDGMENT

Participant's Name: _____

Date of Birth: _____ **Phone Number:** _____

I/We hereby acknowledge that I/we have received and have been given an opportunity to read a copy of the Sunburst Mental Health Services "Notice of Privacy Practices". I/We understand that if I/we have any questions regarding the Notice or my Privacy Rights. I/We can contact Julie Fleck at (406) 885-4074

Signature: _____ **Date:** _____
Participant or Legal Representative

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of attorney, healthcare surrogate etc.)

Signature: _____ **Date:** _____
Sunburst Mental Health Representative

☐ **Participant refuses to Acknowledge Receipt**

Sunburst Mental Health Services
Transportation Authorization Release

Sunburst Mental Health Services Staff Members may provide transportation to participants when the transportation needed is planned ahead of time and is needed to meet treatment plan goals.

I, _____, hereby authorize Sunburst Mental Health Staff to provide transport for_____.

I am asking that this transportation be provided to meet treatment plan goals. By signing this, I am agreeing not to hold the Sunburst staff member or the organization as a whole liable in the event that an accident occurs in the course of transportation.

At times transportation will be provided at the same time it is being provided to another participant. I, _____, agree not to disclose any information pertaining to other participants of Sunburst Mental Health Services.

By signing this you agree not to discuss or disclose any information about another participant you come in contact within the facility or in the community. We ask that you respect the privacy of others and not discuss with anyone anything about the other participants.

Signature: _____ Date: _____

Participant or Legal Representative

Signature: _____ Date: _____

Sunburst Mental Health Representative

Revised 4/15/15