Letter of Introduction for Physical Exam

Date:_____ Patient Name:_____

Consent for Treatment: Residents at MK Place have either been court ordered and dispositioned, or voluntarily committed to reside at MK Place for a specified duration to participate in treatment for Substance Abuse Disorders. As such, MK Place has been granted a general consent for treatment for the residential patients. If MK Place is sending a request for physical exam, consent for examination and treatment is implied. If questions about this general consent arise, please contact Cindy Hansen at MK Place at (208) 234-4722. All information regarding the examination and treatment can be faxed attention Cindy Hansen at (208) 234-2135.

Physical Exam Requirements: Consistent with IDAPA requirements, each new admit to MK Place will be examined physically within 30 days of placement at the residential treatment facility. The physical exam should screen for medical challenges, such items as:

1. A general and comprehensive physical examination which includes a review of oral health and a thorough musculoskeletal exam to rule out injuries consistent with physical abuse and self-injury.
2. Based on provider discretion, a baseline lab analysis (CBC, CMP and THS) and appropriate STI Screening may be conducted. If the patient is on any medications which required monitoring for serum levels (Valproic Acid, Lithium, Tegretol, etc.) these labs should be included in the lab testing.
3. Treatment for any acute illness or problem identified.

A copy and summary of the physical exam will be sent to the directors at MKP and will become part of the patient's permanent medical record. A copy will also be made available to the mental health providers at PMHS.

Randy Vawdrey, COO, NP-C
Physicians Immediate Care- Chubbuck Office
134 West Chubbuck Rad
Chubbuck, Idaho 83202
office: 208-237-7911

Addendum B

IDAPA Standards of Child Care – Physical Exam Requirements

c. Barriers to other placement and the plans to eliminate the barriers. (3-30-01)

02. **Shelter Care More Than Sixty Days.** The organization must develop and follow service plans that comply with these rules, except the initial service plan must be developed after sixty (60) days of admission. The service plan must be updated every ninety (90) days thereafter. (7-1-09)

565. MAINTENANCE OF RECORDS.
An organization must have and follow written policies and procedures for the maintenance and security of records. The policy and procedures must: (7-1-09)

01. **Record Storage.** Ensure that the records are stored in a secure manner. (3-30-01)

02. **Record Confidentiality.** Ensure confidentiality of and prevent unauthorized access to the records. (3-30-01)

03. **Organization of Record.** Require that similar type records be maintained in a uniform and organized manner. (3-30-01)

04. **Record Storage for Closed Organizations.** Before an organization ceases operations, it must arrange with the Department for the storage of all child and adoptive family records required to be maintained by rules. (3-30-01)

566. RECORD RETENTION.
Except for an adoptive record, records must be maintained for at least seven (7) years after the child has been released from the organization's care or until the child reaches the age of twenty-five (25), which ever is longer. A record for an adopted child and adoptive parent must be kept forever. The record for each applicant for a foster care license or certification or an application to adopt where there was no adoptive placement must be maintained for at least seven (7) years after provision of services has ended. (7-1-09)

567. -- 569. (RESERVED)

570. REPORTING OF CHILD ABUSE, NEGLECT, AND ABANDONMENT.
All suspected incidents of child abuse, neglect, or abandonment must be reported immediately to law enforcement or the Department as required by Section 16-1605, Idaho Code. The chief administrator or designee of the children's agency or facility must ensure the safety and protection of children when the allegation is against an organization's staff or volunteer and must initiate a thorough investigation and administer appropriate disciplinary action, when indicated. (7-1-09)

571. HEALTH SERVICES.
The organization must provide a physical exam within the last year by a licensed physician when the child has been in ~~continuous care. If a child has not been in continuous care, a physical must be done within thirty (30) days of~~ admission by a licensed physician. Annual physical exams must be provided for a child two (2) years of age and older, and on a schedule determined by a pediatrician for a child under two (2) years of age. Documentation must be maintained of current immunizations or provisions for immunizations as required by Section 39-4801, Idaho Code, within thirty (30) days of admission. The organization must provide documentation of medical care for the treatment of illnesses, carrying out corrective measures and treatment, and for the administration of medication as ordered by the physician. (7-1-09)

572. DENTAL SERVICES.
For children three (3) years of age and older, the organization must ensure and document the child has had a dental exam within the last nine (9) months or a dental exam within three (3) months of admission, a yearly dental exam and necessary dental treatment, including prophylaxis, extraction, repair and restoration. The organization must make provisions for appropriate dental care for a child under the age of three (3) when the child's dental needs indicate. Documentation of all medical treatment provided while the child is in care and documentation of applicable medical insurance provider, policy numbers and who holds the policy must be maintained. (7-1-09)

573. NON-VIOLENT PHYSICAL INTERVENTION.

Addendum D

Physicians Mental Health Services

Physicians Immediate Care Center

Consent to Treatment

I understand that as a client of Physician's Mental Health Services, (PMHS) and Physician's Immediate Care Center, I am eligible to receive mental health and medical services. The type and extent of services I receive will be determined following an initial assessment and evaluation. The goal of the assessment process is to determine the best course of treatment for my current circumstances. Typically, treatment is provided over the course of several weeks to several months and may be longer if needed. I also understand that while I am receiving treatment at PMHS or PICC, I will have access to a 24 hour mental health crisis line.

I understand that all information shared with the clinicians at PMHS and PICC is confidential and that no written information will be released without my consent. I further understand there are specific and limited exceptions to this confidentiality which include the following:

A. If there is imminent danger to myself or others, the clinician is ethically and legally bound to take necessary steps to prevent such danger
B. When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that PMHS services are provided by a range of mental health professionals and those professionals that treat me will provide the treatment they feel is in my best interest. I understand that while my mental health treatment may provide significant benefits, it may also pose some risks. Some of the risks may include the following: psychotherapy may elicit uncomfortable thoughts and feelings, prescribed medications may have unwanted side effects, CBRS providers may teach me skills out of my comfort zone. As it is unfeasible to list all possible risks involved, it is important to recognize that any medical treatment provided comes with risks and PMHS will do everything it can to minimize and/or eliminate those risks.

If I have any questions regarding this consent form or about the services offered at PMHS or PICC, I may discuss them with my provider or the administrator. I have read and understand the above and give consent to participate in the evaluation and treatment offered to me by PMHS or PICC. I also understand that I may discontinue services at any time and an appropriate referral may be made on my behalf.
By signing below, I have read this consent to treatment and have discussed my concerns with the provider and/or administrator and am willing to accept treatment in spite of the possible risks involved.

_____ _____

Client Name (please print) Client Date of Birth

_____

Client or Guardian Signature Printed Name Date

Addendum H
Release of Information

Physicians Mental Health Services

Medical Record No.: _____

Authorization to Disclose Protected Health Information

Patient: _____ Date of Birth: _____
Address: _____
_____
Telephone: _____

Other names under which the patient has been treated: _____

I authorize MK Place and its employees, agents or associated health care practitioners ("PRACTICE") to use or disclose the patient's protected health information as described below.

1. **Relevant Time Period.** PRACTICE may use or disclose information relating to health care provided during the following time period:
   - ☒ Anytime.
   - ☐ Health care provided between (*date*) _____ and (*date*) _____.

2. **Types of Information.** PRACTICE may use or disclose the following type(s) of information:
   - ☒ Any information concerning the patient's health care or payment during the relevant time period.
   - ☒ Medical records concerning the patient's health care during the relevant time period, including:
     - ☒ Records from the patient's chart (*e.g., history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, etc.*)
     - ☒ Diagnostic images, films or other recordings (*e.g., x-rays, MRI scans, CT scans, etc.*)
     - ☐ Psychotherapy notes ***[Note: cannot be combined with authorization for other records]***
   - ☐ Billing and payment records for health care rendered during the relevant time period.
   - ☐ Other: _____

3. **Persons to Whom Disclosure Allowed.** PRACTICE may disclose the information to the following entity(ies):
   Name or description: Physician's Immediate Care Center/Physician's Mental Health Services
   Address: 475 Yellowstone Ave.
   Pocatello, ID 83201
   Phone number: 208-232-0021 Fax: 208-232-0031

4. **Purpose.** PRACTICE may use or disclose the information for the following purpose(s):
   - ☒ The disclosure is made at the patient's request.
   - ☐ For a potential or pending legal proceeding.
   - ☐ For marketing. PRACTICE *will/will not (circle one)* receive remuneration form a third party for the use or disclosure of the information.
   - ☐ Other: _____

I understand that I have the right to revoke this authorization at anytime except to the extent that PRACTICE has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Matthew Andersen, Administrator

I understand that PRACTICE may not condition the patient's health care on this authorization unless (1) the purpose for PRACTICE's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by PRACTICE pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: _____.
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

_____ _____
Signature Date

_____
Authority or relationship to the patient

** Give a copy of the authorization to the patient or personal representative.*

Kim C. Stanger
208-388-4843
kstanger@hawleytroxell.com

PATIENT DATA

PATIENT FIRST _____ M_____ LAST_____
Mailing Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone _____ Other/ Cell Phone_____
Date of Birth_____ Social Security #_____ Sex Male Female
Father_____ Date of Birth_____
Address:_____ Phone_____
Email_____ Employer _____
Mother _____ Date of Birth _____
Address: _____ Phone _____
Email_____ Employer_____
Legal Guardian (*If other than parents)*_____ Phone_____
Address_____ City _____ State____ Zip _____

EMERGENCY CONTACT

EMERGENCY CONTACT: Name_____ Relationship_____
Address_____ City_____ State_____ Zip_____
Home Phone _____ Work Phone _____Other/Cell Phone _____

OTHER

Primary Care Doctor_____ Preferred Pharmacy_____
How did you hear about us?_____ Preferred Language_____
Race: Black/African American Native Hawaiian/Pacific Islander Native American/Native Alaskan
Asian White Decline to provide
Ethnicity: Hispanic Non-Hispanic Decline to provide

INSURANCE INFORMATION

PRIMARY INSURANCE _____Policy ID #_____
Policy Holder Name _____ Date of Birth _____
Relationship to Patient_____
SECONDARY INSURANCE _____Policy ID #_____
Policy Holder Name_____ Date of Birth _____
Relationship to Patient_____
I HAVE NO INSURANCE *Individuals without Health Insurance are required to pay for services at the time of check in. Please inquire at front desk for our self-pay cost structure.*

AUTHORIZATION AND AGREEMENT FOR TREATMENT

CONSENT TO TREATMENT: I hereby give my authorization and consent to treatment and procedures. I certify that no guarantee or assurance has been made as to the results of such treatments or procedures. ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMTION: I request that payment of authorized benefits on my behalf, be made to Physicians Immediate Care (PICC) for services rendered to me. I authorize any holder of medical information about me to be released to my insurance carrier and its agents; any information needed to determine these benefits or the benefits payable for the related services. I authorize PICC to release any medical information to the patient's treating physicians. I authorize PICC to use and disclose my protected health information in order to carry out treatment, payment and healthcare operations including but not limited to contracting laboratory, radiology, billing and/or other hospital physicians if deemed necessary.

GENERAL INFORMATION ON PAYMENT AND PROCEDURE

If after sixty (60) days the insurance has not been responded to the claim, the billing is expected to be paid in full by the responsible party. Patients with health insurance should remember that services are rendered and charged to the patient. Any disputes over an insurance claim are a matter between the patient and the insurance carrier. Should a dispute arise, we will make every effort to resolve the claim. Although we have lab and x-ray facilities, at times other tests may be done outside PICC. These are not included in our billing. PICC is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. The patient is responsible for payment in full regardless of the interpretation of what is usual and customary by a given insurance company.

AGREEMENT TO PAY FOR SERVICES

For the care and treatment provided to the patient, I promise to pay PICC all charges for services rendered to or in behalf of the patient. If I fail to pay for services, or sign an agreed payment schedule, I will be responsible for all cost of collection, including but not limited to, court costs and fees, attorney fees, and a collection fee of twenty-five percent (25%) of the unpaid balance assigned for collection.

I HAVE READ AND UNDERSTAND THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS

Patient Signature(or Responsible Party) _____ Date_____

PHYSICIANS IMMEDIATE CARE CENTER

Health History-Child/Dependent

Patient Name:_____ Today's Date:_____

Date of Birth_____

Preferred Pharmacy: _____

Current Medications (including herbs, vitamins, supplements, over the counter medications)Use back of form if needed:

_____ _____

_____ _____

_____ _____

Please list any medication allergies: _____

Does the patient have any of the following conditions?...

Asthma	Yes	No
Diabetes	Yes	No
Kidney Compromise/ Disease	Yes	No
Heart Problems	Yes	No
Depression	Yes	No
Hospitalizations/Surgeries	Yes	No
Other	Yes	No

Please explain any YES responses:

_____

_____

Social History

Does the patient smoke/chew/ vape? Yes No

If yes, how much? _____

Does the patient drink alcohol? Yes No

If yes, how much? _____

Exposure to any second hand smoke in the home? Yes No

Family History	**Who?**		**Who?**
Heart Disease	Yes/No _____	Diabetes	Yes/No _____
Cancer	Yes/No _____	High Blood Pressure	Yes/No _____
Stroke	Yes/No _____	Other	Yes/No _____

Preventative Care

Is Physicians Immediate Care the patients Primary Care Office? Yes No

Which Provider does the patient prefer to see? _____

List of current Doctor(s) and date last seen? _____

_____

Are Immunizations Up to Date? Yes No

If no, please list which ones are needed to be current with age?_____

HAWLEY TROXELL

Physicians Immediate Care Center

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your health information and to notify you of our legal duties and privacy practices with respect to your protected health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 C.F.R. part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your protected health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose information for purposes of treating you, e.g., our staff may use your information or disclose your information to another health care provider to diagnose or treat you. In addition, we may use or disclose your information to provide appointment reminders, or to provide information about treatment alternatives or other health-related benefits and services we offer that may be of interest to you.

Payment. We may use or disclose information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose information for certain other purposes allowed by 45 C.F.R. § 164.512 or other applicable laws and regulations, including the following purposes:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law, e.g., to report abuse or neglect or certain other occurrences.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities, e.g., to report certain events or diseases.
- For certain public health oversight activities, e.g., to allow public health agencies to conduct investigations or inspections.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- Subject to specific limitations, in response to certain requests by law enforcement, e.g., to help identify or locate a fugitive, witness or victim, or to report a crime.
- For research purposes if certain conditions are satisfied.

2. **Disclosure to Persons Involved in Your Healthcare.** Unless you tell us otherwise in advance, we may disclose information to a member of your family, relative, friend, or other person who is involved in your healthcare or the payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. If you object to such disclosures, please notify the Privacy Officer identified below.

Kim C. Stanger
208-388-4843
kstanger@hawleytroxell.com

HAWLEY TROXELL

Physicians Immediate Care Center

3. **Uses and Disclosures With Your Written Authorization.** We will make other uses and disclosures of your information only with your written authorization. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction.
- We normally contact you by telephone or mail at your home address. We will accommodate reasonable requests to contact you by alternative means or at alternative locations.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice.** We reserve the right to change the terms of our Notice of Privacy Practices at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or the Privacy Officer identified below.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer identified below. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact our Privacy Contact:

Privacy Officer:	**Randy Vawdrey,COO**
Phone:	208-237-7911
Address:	134 W Chubbuck Chubbuck , Id 83202
E-mail:	randy@pocatellopicc.com

8. **Patient or Guardian Signature**_____

9. **Effective Date.** This Notice is effective _____, 20___.

Kim C. Stanger
208-388-4843
kstanger@hawleytroxell.com