Client ID: _____

Client Name: _____

888.949.4864
ValleyCares.com

Welcome to Valley Behavioral Health!

Valley Behavioral Health provides behavioral health and substance abuse services in many different locations.

After your intake assessment, you will meet with a therapist to complete a Care Plan. Your Care Plan is specific to you and your needs. Many different treatment options are available. Please work with your treatment team to find the method(s) and setting(s) that will meet your needs.

We live in an area with many available resources! Please ask to meet with a case manager if you are interested in learning more about programs or benefits available with providers other than Valley Behavioral Health.

We are happy you are here! We hope you will allow us to continue to serve you.

If you choose to discontinue services with Valley Behavioral Health, we will leave your chart open for thirty (30) days. During that time we will try to reach you in hopes you will re-engage in services. If we are not able to reach you, your chart will be closed. If you change your mind, you are welcome to re-start services with us at any time.

Some important contacts:

Valley Behavioral Health: 888-949-4864
Valley Behavioral Health Client Advocate: 801-263-7135
National Alliance on Mental Illness- NAMI Utah: 801-323-9900 UNI Crisis Line: 801-587-3000

_____ _____

Signature of client acknowledgement Date

MRF03 7-2019

APPLICATION/REGISTRATION FOR SERVICES

VBH #:_____

Client Information

Client Legal Name: _____ Client Preferred Name:_____

Prior Names:_____ DOB: _____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Primary Language: ☐ English ☐ Spanish ☐ Other_____ Religious preference: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Race: ☐ Alaska Native ☐ Asian ☐ Black/African-American ☐ Native American ☐ White
☐ Pacific Islander or Native Hawaiian ☐ Other single race ☐ 2 or more races ☐ Decline to answer

Ethnicity: ☐ Dominican ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Assigned Gender: ☐ Male ☐ Female

Gender Identity: ☐ Agender ☐ Female ☐ Male ☐ Genderqueer ☐ Non-binary ☐ Transgender ☐ Other
☐ Don't know ☐ Decline to answer

Sexual Orientation: ☐ Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Don't know ☐ Other
☐ Decline to answer

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other ☐ Decline to answer

Currently in the U.S. Military: ☐ Yes ☐ No

Prior experience in the U.S. Military: ☐ Yes ☐ No

Are you homeless: ☐ Yes ☐ No

Parent (if client is a minor), Guardian, or Spouse Information Is the client a minor? ☐ Yes ☐ No

Parent/Guardian/Spouse Name: _____Date of Birth: _____SS:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Emergency Contact

Next of kin:

Name: _____Relationship to Client:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Other emergency contact:

Name: _____Relationship to Client:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Email:_____

Insurance Do you have Insurance: ☐ Yes ☐ No

Name of Insurance: _____Phone #:_____

Subscriber Name: _____Subscriber Date of Birth:_____

Subscriber (Policy) ID#:_____Relation to Client:_____

Primary Care Physician Do you have a Primary Care Physician: ☐ Yes ☐ No

Name:_____Specialty:_____

Address:_____City:_____State:_____Zip:_____

Office #:_____

Referral Source ____ Family _____ Friend ___ Hospital ____ Other: _____

Name:_____ Relationship to Client:_____

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

Home #:_____ Cell #:_____ Email:_____

Acknowledgements

- I have received a copy of Valley's Notice of Privacy Practices.
- I have received a copy of Valley's Client Rights & Responsibilities.
- I have received a copy of the Advance Healthcare Directive brochure.

  ☐ I have an Advanced Care Directive ☐ I do not have an Advanced Care Directive
- I will: ☐ Request a copy of the Medicaid Handbook ☐ Download a copy of the Medicaid Handbook
- I understand all medications given to clients by Valley through medication monitoring are filled by or transferred to ValleyRx.
- I understand if I am placed on medication monitoring as part of my treatment, all medications prescribed from all non-Valley providers must be given to Valley to monitor, and Valley assumes the final responsibility for medication refills. If my treatment does not include medication monitoring, I am responsible for all medication refills that are not prescribed by Valley.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Valley Behavioral Health.
- I understand that if I have a grievance, I have the right to file a complaint with Valley's Client Advocate at 801-263-7135 and/or DHS Licensing at 801-538-4242/dhslicensing@utah.gov.

_____ (initial) I accept and understand the above acknowledgements.

_____ (initial) ***Abuse or Violence***: I acknowledge and understand that Valley may have a legal obligation to report or make referrals in instances of abuse of children and elderly or vulnerable adults to appropriate governmental or law enforcement agencies, and, further, that Valley may have a legal obligation to report or make referrals in instances of family violence or threatened crimes to appropriate governmental or law enforcement agencies. I further consent to such reports and/or referrals by Valley.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

I certify that I understand the above information and that it is accurate and complete.

_____ _____

Signature of Client or Legal Representative Date

_____ _____

Printed Name of Client or Legal Representative Relation to Client

_____ _____

Valley Staff Signature Date

CONSENT TO TREATMENT

Client Name: _____
VBH #:_____
DOB: _____

CONSENTS/AUTHORIZATIONS

☐ Yes ☐ No I voluntarily consent (or I voluntarily provide consent for my child or the individual who I am legally responsible for) to receive treatment from Valley Behavioral Health. I have completed the Application/Registration form and reviewed the Privacy Practices statement and Fee Agreement. I fully understand these documents and agree to their terms.

☐ Yes ☐ No I understand that I may stop my treatment with Valley Behavioral Health at any time. The only thing I will be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court-ordered, I will have to answer to the court).

☐ Yes ☐ No I authorize Valley Behavioral Health to use my picture as part of my electronic medical record. Images will be stored in a secure location and only authorized staff will have access to them.

☐ Yes ☐ No *Emergency Medical Care*: I consent to receive first aid and emergency medical treatment. This consent would apply if I have an accident, injury, illness, or other medical emergency. I understand this applies only during treatment with Valley Behavioral Health (Valley). This also applies to minors admitted by a parent or guardian.

☐ Yes ☐ No *Electronic Communication*: I consent to receive electronic communications from Valley staff via email and/or text messages regarding my medical care and treatment, including communications about my prescriptions, appointments, and billing. I understand that there is a risk with electronic communication of being intercepted by third parties or transmitted to unintended parties. I understand that any email and/or text communications between Valley and myself regarding my medical care and treatment may be printed out and made a part of my medical record. I understand that in an urgent or emergency situation, I should not rely on electronic communication and call my provider or go to the Emergency Room. I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

☐ Yes ☐ No *Treatment*: I consent to treatment and testing/assessment by Valley whether face-to-face or via Telehealth. I understand testing includes, but is not limited to, intellectual, cognitive, developmental, and functional testing. I understand further informed consents may be required as treatment needs progress.

☐ Yes ☐ No *Treatment*: I consent to have blood drawn, urine samples tested, and/or other specimen testing if requested by my provider. I understand further informed consents may be required as treatment needs progress.

☐ Yes ☐ No *Primary Care Provider*: I authorize release of my treatment information to my Primary Care Provider for the purposes of continuity of care. If I have substance use diagnoses, I understand I am required to fill out a Release of Information form to release those specific records.

CONSENTS/AUTHORIZATIONS *(conrinued)* VBH #:_____

☐ Yes ☐ No ***Transfer/Discharge from Valley***: I authorize release of my treatment information in the event I am discharged or transferred from Valley services to the receiving clinician and/or program for the purposes of continuity of care. If I have substance use diagnoses, I understand I am required to fill out a Release of Information form to release those specific records.

I certify that I have read the above Consent to Treatment and that I fully understand and agree with its terms. I understand this consent is valid for one year and I have the right to withdraw consent at any time and for any reason.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

I further understand I will be asked for consent and re-signature annually.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Printed Name of Client or Legal Representative Relation to Client

_____ _____
Valley Staff Signature Date

CLIENT FEE AGREEMENT

Fee Effective Date:	Client #:	Unit #:	Date of Birth:
Client Name:		SSN:	
Address:		Email:	
City:	State:	Zip:	
Home:	Cell:	Insurance:	

BY SIGNING THIS PAGE, I AGREE TO THE FOLLOWING ASSIGNMENT OF BENEFITS:

- I am a client with county funding or am unfunded □ Yes □ No - If yes, I agree to pay the corresponding fee/co-pay on a sliding fee scale based on my current income verification and dependents for clinical services. This fee is applicable to Outpatient or Residential services.
- Medicaid members do not have to pay for covered services received when they have Medicaid coverage.
- I accept responsibility for payments due for all services received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of Valley's contract with your insurance company.
- I understand that my insurance may not cover all services provided, and that I will be expected to pay for all uncovered services at the self-pay rates.
- I understand that Valley will bill my health insurance or other payor the full cost of services for all covered treatment and services that I receive.
- I understand that I will be expected to pay a discounted self-pay rate for services provided when I choose not to use my insurance or other funding.
- I understand that I must notify Valley of any changes to my insurance or coverage, and that by failing to do so I will be liable for the self-pay rate for all services provided.
- I understand that if my insurance is terminated and I am not covered on the date of service, I will be charged self-pay rates for all services performed.
- I agree to send Valley all payments from insurance or third-party payors that I receive directly, and that failure to do so will result in my being liable for such payments.
- I understand that a $25.00 service fee will be charged for each returned check.
- I understand that after 90 days of non-payment, Valley has the right to refuse to provide additional services, and to send my account to a collection agency for resolution.
- If my account is sent to a collection agency, I understand that I am liable for all costs including court filings, constable fees, attorney fees and interest accumulated at the legal rate on the unpaid balance until the balance is PAID IN FULL.

NEW CHOICES WAIVER (*IF APPLICABLE*)

- I and/or my designee agree to the following regarding payments for my Medicaid Liability:
  Rules and Regulations for Medicaid:
  - I understand that I am responsible to stay financially eligible for Medicaid. I am responsible to pay the Medicaid Liability, if applicable, to the Department of Workforce Services each month to remain in compliance with the rules and regulations of Medicaid.
  - I understand that the amount I pay is determined by the information I have given to my Department of Workforce Services Medicaid Worker.
  - I understand that failure to pay this amount can result in a loss of benefits and I may be disenrolled from FlexCare and the Medicaid New Choices Waiver Program.

CLIENT FEE AGREEMENT

- In signing as Financial Designee, along with this full agreement, I also agree I will assist this New Choices Waiver client in notifying Medicaid of all changes financially or otherwise applicable and assist the client in staying eligible for Medicaid during times of annual reviews and any documentation needed for verifications throughout the year.

- I also understand that I am responsible for the following while on the New Choices Waiver Program:
  - I understand that I am responsible to pay my Room & Board to the facility I reside in.
  - I understand that I will be financially responsible for items not covered by Medicaid, such as over-the-counter pharmacy products, co-pays on medical visits and hospital stays, and items used that may not be included with room and board agreement.
- I certify that the above information is accurate and complete. I agree to pay the full cost of services if I should become disenrolled from the New Choices Waiver Medicaid Program. I agree to notify my Department of Workforce Services Medicaid Worker of any and all changes to my income, including any medical deductions and/or insurance premiums.

AUTHORIZATIONS

- I authorize my insurance company or third-party payor to make payments, otherwise payable to me, directly to Valley. In the event that benefits paid exceed the total cost of services, Valley will be responsible for issuing a refund.
- I authorize Valley to pre-authorize with my insurance company, and to appeal on my behalf, any decision made by the insurance company regarding payment.
- I authorize Valley to disclose protected health information (PHI) to my insurance company, or any entity responsible for payment for my treatment, in order to obtain reimbursement.

This fee agreement covers all services provided by Valley Behavioral Health including both mental health and substance abuse.

I certify that the above information is accurate and complete.

Applicant's Signature:_____Date:_____

Authorized Representative Signature:_____Date:_____

Printed Name of Authorized Representative:_____Relationship:_____

Valley Staff Signature:_____Date:_____

Client No-Show and Late Cancellation Procedure

Valley Behavioral Health (Valley) prioritizes effective and personalized care. Clients are expected to attend each scheduled session on time. A cancelled or delayed appointment can negatively impact other clients. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without 24 hours' notice, we are often unable to fill the time slot.

Definition of No-Show: Missing an appointment, providing less than 24 hours' notice that you will miss an appointment, or being more than 15 minutes late to an appointment

By signing below, I understand and acknowledge the following:

____ I have read and understand the definition of No-Show.

____ If I miss an appointment without providing adequate notice, any recurring appointments may be canceled, and someone from my treatment team will reach out to reschedule the missed appointment.

____ If I have 2 no-shows/late cancellations within 90 days, a member of my treatment team will reach out to me to discuss barriers with engaging in treatment, create an engagement plan, and to reschedule the missed appointment if appropriate.

____ I may be offered a temporary scheduling plan as part of the engagement plan, which may include same-day appointments only, a change to in-person or telehealth appointments, or alternative appointment times.

___ I am responsible for attending scheduled services. I can, at any point, reach out to my treatment team to discuss barriers with attending treatment services and create an alternate scheduling plan.

____ If I have 3 or more no-shows within 90 days, I will be discharged from Valley Behavioral Health.

____ Valley will excuse no-shows for emergencies if I communicate the emergency as soon as possible. Emergencies include any of the following, whether it be the client or the client's immediate family: serious or contagious illness, car accidents, or death. Work issues do not constitute emergencies. In the event of bad weather or some emergencies, appointments can be changed to telehealth appointments.

____I understand the importance of communicating with my therapist and my treatment team.

Client Signature: _____ Date: _____

Printed Name: _____

CLINICAL
HEALTH
INFORMATION
EXCHANGE

CHIE CLIENT CONSENT & CHANGE FORM

CLIENT NAME: _____

CLIENT ID #: _____

DATE: _____

The Clinical Health Information Exchange (cHIE) is a statewide electronic system that stores medical information to allow providers in the state of Utah to access your medical information in order to provide quality treatment. Providers using cHIE may include doctors' offices, hospitals, emergency rooms, and urgent care clinics. If you choose to participate in cHIE, the cHIE will collect your medical information from the different places you receive health care. The type of medical information that may be collected and shared via the cHIE are: basic demographics, date(s) seen, diagnosis code(s), medication(s) and schedule(s), and admission, discharge, and transfer information.

Please check one of the consent options below:

- ☐ I consent to share my medical information with the cHIE and allow my medical information to be accessed by participating health care providers through the cHIE.
- ☐ I do not consent to share my medical information with the cHIE.

You can change your consent at any time by going to any participating cHIE health care provider and requesting a change. Changes to your consent will be processed in a reasonable amount of time, and your current consent status will remain until your request can be updated.

By signing this form, I acknowledge that I have read and understand my consent options. I understand I can change my consent at any time by completing a new cHIE Client Consent & Change Form.

_____ _____

CLIENT SIGNATURE DATE OF CONSENT

To protect your privacy and verify your identity, your signature on this form must be witnessed by your health care provider or a cHIE representative.

_____ _____

Name of Organization Name of Witness

As a witness to this consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in healthcare.

CLIENT NAME: _____
VBH ID: _____

INCOME/INSURANCE VERIFICATION FORM

Valley Behavioral Health (VBH) provides discounted fees to consumers who provide documentation of current family income and insurance, which is available throughout the course of treatment.

Monthly Family Income Source

☐Employment/Wages ☐Public Assistance ☐Alimony/Child Support
☐Social Security Benefits ☐Unemployment ☐Worker's Compensation
☐None ☐Other** ☐Unrecorded
**If other please explain: _____

Monthly/Annual Income Client Monthly Income: _____
Client Annual Income: _____
Household Annual Income: _____

Income Documentation Attached ☐Yes ☐No

Number of Dependents _____ (*Client must count themselves as 1 dependent.*)

Insurance Do you have Insurance: ☐ Yes ☐ No
Name of Insurance: _____Phone #:_____
Subscriber Name: _____Subscriber Date of Birth:_____
Subscriber (Policy) ID#:_____Relation to Patient:_____

I am a client with county funding or am unfunded ☐ Yes ☐ No If yes, I agree to pay the following corresponding fee/co-pay on a sliding fee scale based on my income verification and dependents for clinical services. This fee is applicable to Outpatient or Residential services.

Co-pay amount: _____

Justification for adjustment of fee lower than sliding fee scale: _____
_____
_____
_____

Client/Representative Signature:_____Date:_____

Representative Name:_____ Relation to Client:_____

Valley Representative Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES

Valley Behavioral Health
PO Box 572070
Murray, Utah 84157
801-263-7100

Effective date of this notice: 5/8/2019

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.

KINDS OF INFORMATION THAT THIS NOTICE APPLIES TO

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you otherwise known as de-identified data.

WHO MUST ABIDE BY THIS NOTICE

- Valley Behavioral Health employees, staff, students, volunteers and other personnel whose work is under the direct control of Valley Behavioral Health.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your health information
- We are required to provide this notice to anyone who asks for it.
- We are required by law to notify you following a breach of unsecured protected health information.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. However, any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. **Treatment.** We will use your health information to provide you with care and services. This means that our employees, staff, students, volunteers and others, whose work is under our direct control, may read your health information to learn about you and use it to make decisions about your care. For instance, a therapist or case manager may read your chart in order to care for you. We will also disclose your information to others who need it in order to provide you with medical and/or behavioral health treatment or services. For instance, to coordinate care we may send another behavioral health provider who you are seeing an assessment that we performed. If you authorize us to, we may also share and/or access information about you in a Health Information Exchange with other behavioral and medical health providers.
2. **Payment.** We will disclose your health information, as necessary, to obtain payment for the services we provide to you. For instance, we may use your health information to prepare a bill. In addition, we may send that bill, and any health information it contains, to your insurance company. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.
3. **Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. This includes reading your health information, and the information of others, to review the performance of our staff or to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants.
4. **Legal Requirement to Disclose Information.** We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For example, we may be required to disclose your health information if we are audited by an office of the U.S. Dept. of Health & Human Services. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. **Public Health Activities.** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.
6. **To Report Abuse.** We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.
7. **Law Enforcement.** We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations**.**
8. **Specialized Purposes.** We may disclose your health information for a number of specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your information to medical examiners and funeral directors; or for reasons of national security. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with behavioral health care, to protect the health and safety of the inmate and/or others. We may also disclose your health information to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance).
9. **To Avert a Serious Threat.** We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.
10. **Family and Friends.** We may disclose your health information to a member of your family or to someone else who is involved in your care or payment for care. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.
11. **Research.** We may disclose your health information in connection with research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.
12. **Marketing.** We may use your information to communicate with you about a drug or service that is currently being prescribed. Other communications where payment is received by Valley Behavioral Health is considered marketing and requires us to obtain an authorization from you prior to releasing such communication. If you do not want us to do this, contact the Valley Behavioral Health Privacy Officer whose information is listed at the end of this notice in order to "opt out" of such communications. Should you choose to "opt out" it will be treated as if it were a revocation of authorization.
13. **Fund Raising.** We may use your information to contact you to ask for donations to Valley Behavioral Health. We may disclose your information to a related foundation for the same purpose. If you do not want us to do this, contact the Valley Behavioral Health Privacy Officer in order to "opt out" of such communications. Should you choose to "opt out" it will be treated as if it were a revocation of authorization.
14. **Reminders or information.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. (if you do not wish to be reminded, notify your scheduler)

YOUR RIGHTS

1. **Authorization**. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the Valley Behavioral Health Privacy Officer. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.
2. **Request Restrictions.** You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. However, we are not required to agree except to restrict your health information from going to a health plan for purposes of carrying out payment or health plan operations if you have first paid for the health care service or item out of pocket in full. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law or for treatment purposes.
3. **Confidential Communication.** You have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send mail to a different address rather than to your home. Or you may

ask us to speak to you personally on the telephone rather than sending your health information by mail. We will not ask you to explain why you are making the request. We will agree to any reasonable request.

4. **Inspect And Receive a Copy of Health Information.** You have a right to inspect the health information about you that we have in our records, and to receive a copy (hard copy or electronic). This includes your request for us to send your health information to an entity or person designated by you such as a Personal Health Record. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes behavioral health and billing records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the Valley Behavioral Health Privacy Officer. We will respond to your request within 30 days, or as required by contract. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.
5. **Amend Health Information.** You have the right to ask us to amend health information about you which you believe is not correct or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.
6. **Accounting of Disclosures.** You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period that you want the list to cover.

   You may not request a time period that is longer than six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures of information in a facility directory [if applicable]; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.
7. **Paper Copy of this Privacy Notice.** You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the Valley Behavioral Health Privacy Officer.
8. **Complaints.** You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the Valley Behavioral Health Privacy Officer. You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services, at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. If you received treatment for a substance use disorder you may file a complaint with the U.S. Attorney for the state of Utah at 111 South Main Street, Suite 1800, S.L.C., UT 84111. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. We will post the new notice in the lobby areas of our treatment facilities and include the effective date.

WHOM TO CONTACT

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Valley Behavioral Health Privacy Officer
4460 S. Highland Drive, Ste. 230
Salt Lake City, UT, 84124
801-273-6401
privacy@valleycares.com

Copies of this notice are also available at the front desk of any treatment facility of Valley Behavioral Health. This notice is also available by e-mail. Contact the person named above or send an e-mail to: privacy@vmh.com. This notice is also available on our Web site: http://www.valleycares.com

Administrative Offices

PO Box 572070
Murray, Utah 84157
801.263.7100

Contact

Website
ValleyCares.com
Phone
888.949.4864

24-Hour Crisis Numbers

Suicide Prevention Lifeline
(800) 273.TALK [8255]

Salt Lake County
801.587.3000

Tooele County
435.882.5600

UNI Crisis Line
801.587.3000

Resources

888.735.5906 (Voice)
800.346.4128 (Voice to Text V/T)
888.346.5822 (Speech to Speech STS)

Speech Impaired
800.346.4128 (TTY)

Client

Rights and Responsibilities

Valley™
BEHAVIORAL HEALTH

RIGHTS AND RESPONSIBILITIES

You have the right to

- Receive services regardless of race, color, national origin, mental or physical disability, sex, sexual orientation, gender identity, religion, lifestyle, political affiliation, religion or age.
- Be treated with respect and dignity in the least restrictive environment consistent with your treatment needs.
- Information about program specific guidelines, including fees and other costs, as well as reasons for involuntary termination and criteria for re-admission.
- Be free from potential harm or acts of violence while at Valley.
- Receive information on treatment options and alternatives in a way that is clear and that you can understand.
- Take part in treatment planning and decisions about your mental health care including the right to refuse treatment.
- Be free from restraint or seclusion if it is used to coerce (force) or discipline, as a reaction (to retaliate), or for convenience, as specified in Federal Regulations.
- Have your privacy protected and know who has accessed your records.
- Receive a copy of your medical record. You may also ask that it be amended or corrected, when allowed by federal privacy law.
- Receive information on the smoking policy in accordance with the Utah Clean Air Act.
- Receive program specific information about sanctions and consequences for violations.
- Receive treatment in a safe environment.

Additional Rights in a Residential Program:

- To communicate by telephone or in writing with your family, attorney, physician, clergy, counselor, or case manager. This does not apply when the communication is opposed by a licensed professional.
- To be provided with a list of people whose visitation rights have been restricted through the courts.
- To send and receive mail providing that security, health, and safety requirements are met.

You have the responsibility to

- Keep scheduled appointments and cancel 24 hours in advance.
- Be on time for your appointments.
- If you are a parent/guardian and your child is in treatment, you are responsible for making sure your child comes for scheduled appointments.
- Participate with your therapist in your treatment plan and care.
- Tell the secretary or your therapist of changes in your address, phone number, insurance, or financial situation.
- Tell medical staff of all medications you are taking, including medical and mental health prescriptions and over-the-counter medications, herbs, etc.
- Respect the property, comfort, and confidentiality of other clients/staff.
- Refrain from acts of violence or harm to other.
- Follow program participation guidelines.
- Tell your treatment provider when you want to stop services.

Grievance Resolution

File a grievance if you feel you have been treated unfairly or discriminated against for any reason. Contact any of the following:

Valley Client Advocate Phone
801.263.7135

Valley Quality Assurance Phone
888.949.4864

Mail or fax your written complaint to:

Valley Quality Assurance Address
PO Box 572070
Murray, Utah 84157
Fax 801.263.7203

If you believe you have been discriminated against on the basis of disability you may also file a complaint directly with the Secretary of the U.S. Department of the Health and Human Services, at the Office of Civil Rights.

U.S. Department of Health and Human Services, 200 independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201

Valley Behavioral Health will make every effort to ensure that you are afforded these rights and that you are treated with respect and dignity.

These rights and responsibilities are meant to promote your satisfaction.

CHECKLIST

- Talk to your spouse, adult children, family, friends, and doctors about what is important to you.
- Ask someone you trust to be your agent. Discuss your wishes with this person. Select another person to act as your alternative agent.
- Complete an Advance Health Care Directive.
- Have an individual not related to you witness your signature.
- Tell family, friends and doctors that you have an Advance Health Care Directive.
- Give copies to your agent, health care providers, family, close friends, and anyone else involved in your care.
- Have copies placed in your medical file.
- Add that you have a completed Advance Health Care Directive to your drivers license .

RESOURCES

NAMI Utah State Office
1600 West 2200 South, Suite 202
West Valley City, UT 84119
801-323-9900
www.namiut.org

National Hospice and Palliative Care Organization
HelpLine: 800.658.8898
Spanish HelpLine: 877.658.8896
http://www.nhpco.org

Center On Aging: The University of Utah
30 North 1900 East, AB193 SOM
SLC, UT 84132
801.585.9540
http://aging.utah.edu/programs/utah-coa/directives

American Bar Assoc.: Commission on Law and Aging
740 15th Street, NW
Washington, DC 20005-1022
202.662.8690
http://www.abanet.org/aging

CONTACT INFO

Call: **888.949.4864**
Text: **385.474.8887**

ValleyCares.com

Advance Health Care Directive

Effective: September 18, 2019

Valley Behavioral Health recognizes your right to give written and verbal instructions regarding your Health Care treatment and other medical care.

This is done in compliance with the Utah Advance Health Care Directive Act.

Valley BEHAVIORAL HEALTH™

ANSWERS TO FREQUENTLY ASKED QUESTIONS

WHAT IS AN ADVANCE HEALTH CARE DIRECTIVE?

An Advance Health Care Directive is a legal document that allows you to let others know your health care preferences if you are unable to, due to either physical or mental health symptoms. Utah's Advance Directive has four parts:

- Part I: Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.
- Part II: Allows you to record your wishes about health care in writing.
- Part III: Tells you how to revoke or change this directive.
- Part IV: Makes your directive legal.

WHEN CAN I FILL OUT MY ADVANCE CARE DIRECTIVE?

You must be age 18 or older and mentally capable at the time to declare your instructions regarding health care treatment.

HOW DO I FILL OUT MY DIRECTIVE?

Obtain an Advance Health Care Directive from your case manager or therapist.

- Consider the treatment you wish to receive when you are unable to make a decision.
- Decide who you want as your agent.
- Ask an individual to witness that you signed your Advance Health Care Directive in their presence, and you appear to be of sound mind and not under duress - the witness cannot be a relative.

DO I NEED A LAWYER?

No. A lawyer is not needed to complete an Advance Health Care Directive.

WHO MAY BE MY AGENT (ATTORNEY-IN-FACT)?

You may appoint any person you want except your medical or mental health provider(s), an employee of the State Division of Substance Abuse, or any staff member of Valley Behavioral Health. If you do not want to ask a relative or friend to act as your agent, you may ask for a volunteer from your local chapter of NAMI of Utah.

WHAT ARE THE RESPONSIBILITIES OF AN AGENT?

Your agent's power begins when you cannot make or communicate health care decisions for yourself. A physician who has personally examined you must find that you lack the capacity to make a health care decision. To have capacity, you must be able to:

- Understand your medical condition.
- Understand the risks and benefits of your treatment choices.
- Weigh the risks and benefits to form a choice about treatment.
- Communicate your choice to your health care provider.

You may continue to make your own health care decisions if you disagree with the physician's finding. You may be involved in making decisions as long as you want even if you have been found to lack capacity. Your agent and health care providers should try to include you in your health care decisions for as long as you want, even if your decision making capacity is impaired.

WHEN DOES MY AGENT'S POWER END?

When you have the ability to make your own choices, or when you either revoke your Advance Directive, name a new agent, or disqualify your agent.

HOW DO I CANCEL OR REVOKE MY ADVANCE HEALTH CARE DIRECTIVE?

You may revoke your directive even if a physician has found that you lack health care decision making capacity. Here's how:

- Revoke your Advance Directive in the presence of a witness. The witness must be 18 years or older and not your agent or alternative agent.
- Complete a new Advance Directive. If you sign a new directive the most recent one applies.
- Sign a written revocation or write 'void' across your Advance Directive.

Tell your health care provider or health care facility you have revoked your Advance Directive. Give them a copy of your new directive once it is complete.

DO I HAVE TO HAVE AN ADVANCE HEALTH CARE DIRECTIVE?

No. Utah law does not require you to have an Advance Health Care Directive.

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