

North Slope Borough

Department of Health and Social Services

P.O. Box 69

Barrow, Alaska 99723

Phone: (907) 852-0366

Fax: (907) 852-0268



Congratulations,

You've taken the first step to making some big changes in your life and the lives of your family. We are here to help in any way that we can. The services we provide are confidential and will be provided according to your individual needs and wishes.

We understand that it takes courage to seek help and we will do everything we can to make your experience with us productive and helpful.

Attached to this letter is the *Request for Services Packet* (these forms are not the assessment).

- ✓ Fill in the forms completely so we can match your service needs and staff best suited for you
- ✓ Return forms to Integrated Behavioral Health at 5200 Karluk (plan on spending 30 minutes)

Our staff will:

- ✓ We will provide you with an orientation to services and answer any questions you may have
- ✓ We will schedule and provide you with an assessment appointment (plan two hours for this assessment)

If you are in a village, ask your Village Clinic staff to fax the completed forms back to us at **(907) 852-0268**. You can use a private fax machine or through the postal mail to return the forms to us if you choose. Our Records staff will then call to finalize your forms, schedule an assessment appointment for you, and complete your client orientation.

Please feel free to call at **852-0366** with any questions or concerns. Thank you for your patience and persistence in completing the paperwork.

Quyanaqpak,

Ellen Sovalik

Deputy Director, Behavioral Health

Attachments:

- HIPAA Notice of Privacy Practices (yours to keep)
- Notice of Privacy Practices - Acknowledgement
- Authorization for Treatment/Service Agreement (personal copy provided upon request)

NSB BEHAVIORAL HEALTH
HELP • HOPE • HEALING

Integrated Behavioral Health



Authorization for Treatment/Service Agreement

1. I, _____ (*Name*), _____ (*DOB*), hereby authorize NSB Integrated Behavioral Health Services to conduct assessments, provide treatment recommendations, provide counseling services, provide substance abuse services, provide psychiatric services, provide case management services, and/or assist with residential treatment placement to help me with my problems.
2. I understand that services that I request may not be provided and/or may be delayed, depending on the nature of my request(s), the availability of the requested services, and the availability of IBH staff. If NSB Integrated Behavioral Health is unable to provide services, I will be informed about how and where I can receive services.
3. I understand that I will be informed of any type of treatment I will receive in advance of said treatment, and that I have the right to be informed of possible beneficial effects, side effects and alternative modes of treatment.
4. I understand that I am expected collaborate in my treatment planning, appropriate discharge planning, and to follow through with agreements that I make during the course of treatment. I am responsible to cooperate and participate with the treatment plan, including attending sessions on time and maintaining contact with providers when appropriate.
5. I understand that I may refuse any examination or treatment at any time and will be told of any consequences that may occur resulting from my actions.
6. I understand I have the right to confidentiality of records and information about me is not given to anyone unless I agree in writing. Integrated Behavioral Health will give out information only when:
 - Information about clients such as age and marital status is needed for statistical purposes.
 - A Court Order or Subpoena request records.
 - Probable danger to others or myself is evident, and Integrated Behavioral Health Services needs to protect me and/or others.
 - When state and federal laws allow, or order, that information be released, especially information related to the abuse, neglect, or exploitation of a child, an elderly adult, or a disabled person.
7. I understand this agreement and have received or been offered a copy of this form.

Signature of Client

Printed Name

Date

Parent/ Guardian Signature
(If under 18 or determined by the Court)

Printed Name

Date

Staff / Witness Signature

Printed Name

Date

Client Address (PO Box/House # & Street)

City/Village, State, zip code

Contact Number(s)



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised: September 23, 2013

The North Slope Borough's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review the notice before signing this acknowledgement. As stated in the notice, the terms of the notice may change. If the notice is changed, you may obtain a revised copy by contacting the Privacy Officer or asking any NSB staff.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction except in special circumstances, but if we do, we are bound by our agreement.

You have the right to request a list of certain disclosures we have made of your protected health information.

By signing this form, you acknowledge receipt of the North Slope Borough Health Departments Notice of Privacy Practices.

Date of Birth

Date

Printed Name of Patient

Printed Name of Authorized Representative

Signature of Patient or Authorized Representative