SERENITY LANE
Alcohol & Drug Treatment Services

Name:_____ Date: _____

DOB:_____

Welcome to Serenity Lane Telehealth! This orientation should include all of the information for you to get started. **Please review this packet in full, review the Patient Handbook, complete and return all attached forms.** If you have any questions, please contact your primary counselor.

What is Telehealth? Telehealth is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Providers may include primary care practitioners, mental health specialists and counselors. Electronically transmitted information is used for therapy, follow-up and/or patient education, and may include interactive audio, video, and/or data communications. Telehealth has many benefits, including improved access to care by enabling a patient to remain at home or a remote site for care.

Due to COVID-19, the Department of Health and Human Services (HHS) and SAMHSA (Substance Abuse and Mental Health Services Administration) have lifted restrictions previously placed on interactive electronic systems used for communications for Telehealth (such as Skype for Business, etc.). The interactive electronic systems used may not protect the confidentiality of patient identification and imaging data and measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

1. **Zoom for Telehealth Instructions:**
   Please review this attached document carefully and ask your counselor if you have any questions.
2. **Telehealth Informed Consent: Please review this attached document carefully and ask your counselor if you have any questions.**
3. **Consent Packet: Please review these attached documents carefully and ask your counselor if you have any questions.**
   A. Acknowledgement and Consent for Screening, Assessment and Treatment
   B. Abstinence Focused/ Medication Assisted Treatment
   C. Acknowledgement of Risks Associated with Leaving Treatment Early
   D. COVID-19 Notification, Disclosure and Consent
   E. Notice of Privacy Practices
4. Release of Information (ROI) Form for Emergency Contact: This person will only be contact for emergency purposes and will not receive your treatment information unless you fill out a full ROI.
5. Release of Information (ROI) Form : A Release of information is a statement signed by you authorizing us to gi ve information about your treatment to others that you identify. Please fill an ROI out for each person/ organization you would like us to share your information with.
6. Blue Flag Data Request: Serenity Lane offers a service for patients when employers or other referring agencies need feedback regarding evaluation results and compliance with treatment recommendations. This monitoring service is what we refer to as our Blue Flag system. Serenity Lane will only provide this service when the patient requests it and signs an authorization to release information. The signed authorization will specify the types of information that the patient wants Serenity Lane to disclose. Typically, the information includes attendance and participation in treatment as well as showing good faith by completing a treatment plan. At other times, the agency may need the results of drug screens.

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7. **Medication Reconciliation:** Please provide a list of all current medications, including over the counter. Serenity Lane's Medical Director may need to review your medications.

8. **Patient Preferences and Goals Packet:** These forms are to obtain additional information to help Serenity Lane make your safety, preferences and goals a priority while in our care. We want to work with you throughout treatment to create and update a Service Plan that focuses on helping you with problems you are experiencing as a result of substance use, as well as what you wish to accomplish while you are in our care.

9. **Tour of Facility:**
   - Patient is utilizing telehealth services. No tour of facility necessary.

10. **Please review the Patient Handbook (separate file). The following information is included:**
    - Declaration for Mental Health Treatment opportunity;
    - Education regarding Advance Directives;
    - Description of individual rights and Grievance and Appeals policy;
    - Voter Registration opportunity;
    - Ways in which input can be given by patient;
    - Rules regarding confidentiality;
    - Care coordination;
    - After-hours hotlines;

11. **Financial Information (separate file):**
    - Financial review including Terms of Admission (TOA).
    - Billing questions may be directed to Business Office at 1-800-826-9285

By signing this document, I acknowledge that I have received and reviewed each of the documents and instructions listed above and that I consent to the terms in these documents. I understand that if I am not willing to consent to the terms in these documents, Serenity Lane will provide referrals to other treatment providers.

Patient Name:	Date:
Signature:	
Patient Address:	Patient DOB:

Introduction to Serenity Lane virtual recovery services:

Serenity Lane's telehealth services will provide the same exceptional Intensive Outpatient programing via the **Zoom** teleconferencing platform. This will include group sessions and meetings with their counselors.

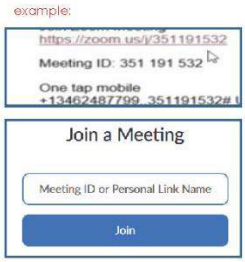
Download Zoom:

Downlaod the **free** version of the **Zoom** app on your computer, phone or tablet.
Create your account, then **activate your account** and sign in using your user name and password.

How it works:

If you have a computer with internet or a smart phone, you can download Zoom and join the meeting using a link or meeting ID provided by your counselor.

1. Open your internet browser.
2. Go to **join.zoom.us**.
3. Enter your meeting ID provided by the host/organizer. This ID will be included with your link information to join meeting from your counselor.
4. You can activate the same window from your app if you have the link information and meeting ID.



How to Call in:

If you do not have internet, a computer or smart phone, there is also a way to call in to the meeting. You will be provided with a call-in number and meeting code. You may use these to join the meeting by phone.

1. On your phone, dial the teleconferencing number provided in your invite.
2. Enter the **meeting ID number** when prompted using your dialpad.

If you have not joined on your computer, simply press # again when prompted to enter in your participant ID.

Common Problems:

Make sure the audio on your phone or computer is turned up and your internet is strong enough to establish a connection. Zoom works well on a variety of internet speeds – if your home internet is causing problems, consider using your smart phone, if you have a data plan.

How to Interact in a Virtual Meeting:

Zoom allows you to "start" or "turn off" video – this is controlled by a small camera icon It also allows you to mute or unmute yourself.

When joining a meeting please mute yourself and only unmute yourself to talk. Background noises are disruptive, especially when there is a large number of people on the call. Your counselor may also mute all participants and unmute you when you're called on to share.

Audio is not muted *Audio is muted*

Etiquette and Support:

We will be opening meetings 15 minutes early for participants to test their connection and trouble shoot any problems. The counselor will take attendance at the start of the meeting. The same rules for attendance apply to these virtual meetings. Arrive on time to be counted.

Telemedicine/Telehealth Informed Consent

Acknowledgement of My Responsibility for Confidentiality

- I understand that in counseling groups, sensitive information about group members will be exchanged.
- I understand that confidentiality and trust of privacy of communication and information, must be a shared responsibility amongst all group members and the leader(s) of the group. It is an integral part of maintaining the safety of the group.
- I understand that group leaders abide by professional, legal, and ethical guidelines of confidentiality established by professional organizations and state law. Legal and ethical exceptions to confidentiality include: 1) danger and/or risk of imminent harm to yourself or specifically identified others; (2) child or dependent adult abuse or neglect; and (3) responses to court order or subpoena or as otherwise required by law.
- I understand that if I discuss risk factors (e.g., suicidal thoughts, homicidal thoughts, self-injury, and abuse) in the group session, I am aware that the group leader(s) may follow up with additional questions about these disclosures in order to assess my current risk level. If I am uncomfortable answering these questions in the presence of the group, I can request for this assessment to be completed after the group with the group leader(s).
- Additionally, I understand that group leaders may contact me after the group for follow-up. Group leaders may recommended additional assistance based upon the level of risk of harm to others or myself.

I understand that confidentiality on the part of group members via telehealth may not be as private as in an office setting. Thus, this agreement is an attempt to provide you and your fellow group members with as much protection of confidentiality as possible. This could be accomplished with the use of a private room or setting, and consider using headphones and a microphone to help maintain confidentiality. It is important to note that confidentiality is not guaranteed and depends on fellow group members' adherence to the following:

What is NOT permissible: I will not disclose to anyone outside the group any information that may identify another group member. This includes, but is not limited to names, physical descriptions, biographical information, and specifics of interactions with other group members. If I breach confidentiality, I understand that I may be asked to leave the group.

If I am receiving individual counseling, I understand that my confidentiality will be maintained unless I choose to disclose this information to the group. I am also aware that my individual therapist and group leader(s) may consult about my treatment in an effort to provide the best care possible.

By signing this form, I understand and agree to the following:

- The laws that protect the privacy and confidentiality of protected health information (PHI) also apply to telehealth. No information obtained during a telehealth encounter, which identifies me, will be disclosed to researchers or other entities without my consent.
- I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time.
- I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telehealth

I hereby consent to engaging in telemedicine at Serenity Lane as part of my therapy. I understand that "telemedicine" or "telehealth" includes the practice of healthcare delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications.

Technology: **I understand that I will need to download an application and/or software to use this platform.** I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Serenity Lane via phone to coordinate alternative methods of treatment.

I hereby consent to and authorize Serenity Lane to use telehealth in the course of my diagnosis and treatment.

Acknowledgement & Consent for Screening, Assessment & Treatment

I understand that Serenity Lane is a not-for-profit substance use disorder treatment program. Serenity Lane is not owned by any other company, organization or agency. Serenity Lane is not an agent for any court, criminal justice system or employer. Serenity Lane exists solely to fulfill its mission of providing quality substance use disorder treatment and related services to patients and their families.

I understand all services provided to me as a Serenity Lane patient are voluntary even though I may have been requested to receive services as a result of an outside agency. I understand that Serenity Lane is providing me services because I have voluntarily requested them. I understand that I have the right to refuse service at any time. I have the right to seek a second opinion (at my own expense.) I understand that employers, courts and criminal justice systems and other outside entities may employ negative sanctions if I do not follow through with assessment, evaluation, treatment, and/or drug screening. Such actions are solely related to the relationship between the outside entity and me. I agree to resolve any disagreements with these outside entities. I understand that Serenity Lane is not responsible for consequences I may encounter because of the decisions and the actions of these outside entities. I understand that it may be necessary for Serenity Lane to make referrals to other providers for services outside of our area of treatment expertise; such as mental health treatment, marriage and family counseling and/or medical services. If Serenity Lane's clinical staff determines that a referral is necessary, a recommendation for appropriate services will be incorporated into my individualized treatment plan.

I understand that Serenity Lane may disclose information to employers, courts or the criminal justice system with authorization. For example, I may request that a letter and progress reports be sent to my employer. Serenity Lane has a patient monitoring program, the Blue Flag Program, which can assist me with this request. Except in very limited circumstances, the sharing of information with anyone is based on my voluntary decision to share such information.

I understand that my picture may be taken for identification purposes during treatment, and I consent to have my picture taken for that purpose.

I understand that submission of urine for Urine Drug Screens will be a regular part of my treatment. I understand that if I choose not to voluntarily submit urine for analysis, it may jeopardize my progress in treatment, up to and including discharge from the program. I agree to submit a specimen that is my own that has not been adulterated in any way. I understand that Serenity Lane contracts with a lab for the analysis, and that the lab will release the results to Serenity Lane.

I understand that I may be contacted by Serenity Lane after my completion of treatment. I have the right to opt out of communication from Serenity Lane, except for billing purposes.

I understand Serenity Lane may use information and communication technology (ICT) to deliver services, to record therapeutic sessions and for surveillance for security/safety purposes. This could include telepractice functions (such as using Skype or similar video conferencing) for long-distance health interactions with a Serenity Lane practitioner over Serenity Lane's network. Other ICT functions could include remote video observation (with or without video recording), and/or audio recording of a

Acknowledgement & Consent for Screening, Assessment & Treatment (continued)

therapeutic milieu such as an individual or group session. At any time I may refuse these telepractice sessions and/or being recorded in a therapeutic milieu with no fear of any negative consequences to myself for refusing except for not being able to use the telepractice function. After a therapeutic milieu recording has been made, I may request that the recording not be used and/or for said recording to be deleted. Recordings of therapeutic milieu sessions are only to be used as a therapeutic resource for me and/or Serenity Lane staff members.

I understand that Serenity Lane may use or disclose my health information for the purposes of treatment, payment and health care operations as detailed in the "Notice of Privacy Practices."

·Treatment: such as, making decisions, planning care, consulting with other health care providers, and
·Payment: such as, determining benefits and eligibility for health plan or insurance coverage, claims management including obtaining or sharing payment-related information, as necessary, with insurance companies or others who may be responsible to pay for some or all of my health care expenses; collection of delinquent bills, and obtaining a credit report.
·Health Care Operations: such as, performing various office administrative and business functions that support Serenity Lane's efforts to provide quality, cost-effective health care. My health information may be used for Quality Improvement activities within Serenity Lane or in conjunction with other agencies or insurers.

I also understand that I have the right to receive and review a written description of how Serenity Lane will handle health information about me. This written description is known as a "Notice of Privacy Practices" and describes how Serenity Lane uses and discloses my health information and my rights regarding my health information.

I understand that the "Notice of Privacy Practices" may be revised from time to time, and that I am entitled to receive a copy of any revised "Notice of Privacy Practices." Copies of the most recent "Notice of Privacy Practices" are available in the reception area. Serenity Lane's web site www.serenitylane.org contains information on how Serenity Lane maintains privacy of my electronic communication. I understand that I may request a written copy of Serenity Lane's most recent Notice of Privacy Practices by asking the receptionist or by reading the copy available in the reception area.

Abstinence Focused & Medication Assisted Treatment (MAT) Agreement

Serenity Lane believes that in order to achieve lasting recovery, abstinence from all addictive mood altering substances is optimal. However, in some cases, Medication Assisted Therapy (MAT) may be an appropriate option as part of the recovery process. Medications, including controlled substances, may be utilized. Medications may be prescribed to treat withdrawal symptoms or to assist in developing recovery.

Prescription medications ordered by other physicians or medical professionals may not necessarily be continued during your treatment. By agreeing to receive treatment at Serenity Lane, you are agreeing to allow our medical staff to recommend what medications are appropriate for you for the duration of your course of treatment with Serenity Lane.

You have the right to refuse the recommendation.

If you have questions about this policy, please feel free to ask your assessment counselor to coordinate a discussion with our medical staff prior to admission.

If you are unwilling to agree to these conditions of admission, we will provide referrals to other treatment providers.

Acknowledgement of the benefits of completing treatment and the risks of leaving early.

While in our care, your well-being is our primary concern.

People with Substance Use Disorder, mental and emotional conditions, often seek to leave treatment before it is wise to do so and place themselves at risk of relapse, overdose and suicidal thoughts. This becomes more likely after a brief period of sobriety where there is a reduction in drug tolerance.

•While in our program, your treatment team will provide you with tools to prevent relapse, including medically assisted treatment, if appropriate for your addiction.
•Entering treatment to heal your addiction, as well as engagement in mental health services, is taking the critical first step toward healing the pain, fear, anxieties and depression that contribute to feelings of suicidality and other symptoms related to mental health. It will also allow your mental health professional to accurately assess, diagnose and treat any mental health concerns. Over time you will learn to improve your confidence, self-esteem and emotional regulation without addictive substances.
•Our Blue Flag program is available to help you address employment and legal matters. Our family program will educate you and your family about the disease of addiction and the process by which your relationships can heal.
•Serenity Lane has a specialty hospital to support you through the withdrawal process and we offer medically assisted treatment at every level of care, when appropriate. While withdrawal may at times feel uncomfortable and overwhelming, our hospital is the safest, most comfortable place for you to be while you become physically stable.
•We will help you achieve long-term sobriety through your development of a strong support system. Treatment provides you with the initial support, education and tools to create the network of support in your community that will be key to sustaining your sobriety.

We want you to be aware that there is risk of adverse outcomes if you choose to leave treatment early.

•**Heightened risk of relapse and fatal overdose.** If relapse occurs, overdose may follow, particularly after a period of sobriety and a reduction in the body's drug tolerance.
•**Heightened risk of suicide.** Suicide, addiction and depression have a close and interconnected relationship. More than 90% of people who fall victim to suicide suffer from depression, have a substance use disorder or both. Completing treatment will reduce the risk of suicide and improve the possibility of achieving sobriety.
•**Heightened risk of extreme withdrawal syndromes.** Withdrawal symptoms should be treated as a medical emergency. They may include confusion, hand tremors, irregular heart rate, dehydration, agitation, fever, seizures, auditory hallucinations, tactile hallucinations and visual hallucinations. Remaining in our hospital through your withdrawal will improve your safety and comfort and reduce the possibility of relapse.

I understand that leaving treatment early, prior the treatment team's recommendations completed puts my health and mental well-being at risk. I understand that Serenity Lane may contact family members, healthcare professionals, referents, stakeholders, or emergency services (911) if we believe you are in imminent danger to yourself or others.

COVID-19 Risk Notification, Disclosure and Consent

Serenity Lane recognizes and supports the right of each patient and or their Medical Power of Attorney to make choices regarding behavior, treatment and lifestyle. As professionals, and caring individuals, we have a responsibility to inform and caution you regarding actions that may cause you harm in this Pandemic COVID-19 environment.

This Notice is our effort to provide you information on the risks of COVID-19 and the actions that can be taken to reduce the risks and to assess your decision to attend treatment at Serenity Lane.

WHAT IS COVID-19?

COVID-19 is an illness caused by a virus. A virus that is invisible and infectious. There is currently no vaccine for COVID-19 and the CDC considers its spread to be a pandemic (widespread). Symptoms of COVID-19 can include the following, among others:

> Fever, Cough; Shortness of breath or difficulty breathing; Chills; Repeated shaking with chills and muscle pain; Headache; Sore throat; New loss of taste or smell.

Symptoms of COVID-19 can arise 2-14 days after exposure to the virus. Therefore, people may not have symptoms, but can still have and spread COVID-19.

Should I decide to attend treatment at Serenity Lan, and if I develop any of the symptoms for COVID-19, it is my responsibility to inform staff of my symptoms as soon as possible.

COVID-19 is usually spread from person-to-person between people who are within six feet of one another through respiratory droplets produced when an infected person coughs, sneezes, or talks. And, while less critical, touching contaminated surfaces.

I understand that by attending groups with other patients, a patient like myself will be at a risk of contracting COVID-19 according to the CDC and public data. Some patients may be at higher risk due to age and other medical compromising conditions. Among those compromising conditions are the following.

> **65 years old or older; Chronic lung disease; Heart disease; Moderate to severe asthma; Immuno-compromised systems through among other things, cancer treatment; smoking; bone marrow or organ transplants, prolonged use of other immune weakening medications, Severe obesity, Diabetes, Chronic kidney disease requiring dialysis, and Liver disease.**

MITIGATION STEPS

Steps to help mitigate the spread of COVID-19 in the treatment facility by patients and staff include the following preventative measures:

- **Wear a mask while around others**
- **Wash hands often with soap and water for at least 20 seconds**
- **Utilize hand sanitizer and rub hands together until they feel dry**
- **Avoid touching eyes, nose, and mouth**
- **Avoid close contact with sick or infected people**
- **Put some distance, at least *six feet*, between myself and others even if they do not show symptoms**
- **Cover coughs and sneezes and immediately wash hands**
- **Avoid sharing items, such as dishes, drinking glasses, cups, utensils, towels, or bedding**

Avoid close contact at mealtimes or in any other setting where more than 2 people are gathered.

The Oregon Health Authority has placed restrictions on the coming and going of family members.

Should I decide to attend treatment at Serenity Lane, I will engage in these preventative measures and I will encourage all others to do so.

I understand that it is very difficult to determine who may have COVID-19 from day to day due to testing limitations and carriers of the disease who do not show symptoms. This is particularly so when there are people coming and going. It is not possible to prevent the existence of the virus. At best, the above practices can mitigate the spread of the virus among people.

Serenity Lane will make their best efforts following CDC and local Public Health Guidelines, along with the Serenity Lane's COVID-19 Response Team protocols to mitigate the spread of COVID-19. However, I also understand that Serenity Lane, even with their best efforts, cannot guarantee that COVID-19 will not appear or spread in the treatment facility or that I will not contract COVID-19.

Confidentiality

Serenity Lane is dedicated to providing you with the safest and most confidential treatment environment possible during the COVID-19 Pandemic. In order to accomplish this, if you exhibit symptoms of COVID-19 while residing at Serenity Lane, we may need to share your symptoms with staff, patients and agencies that provide oversight, including but not limited to, Lane County Public Health and the Oregon Health Authority. Your confidentiality is important to us and we will make it a priority to share only the minimum information necessary.

Per the Health Insurance Portability and Accountability Act (HIPAA), certain situations that pose a serious and imminent threat to the health or safety of a patient or others may permit the disclosure of patient-specific information or information on visitors to prevent or lessen the threat. **I understand that in order to help Serenity Lane protect the health of those in treatment, as well as Serenity Lane staff during the COVID-19 Pandemic, Serenity Lane may need to disclose my Protected Health Information (PHI) to Public Health in the event that I exhibit symptoms of COVID-19**.

I understand that I may further research information about COVID-19 by contacting the CDC (cdc.gov or 800-232-4636) or asking Serenity Lane staff about this Notice.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD, AND CONSIDERED THE CONTENTS OF THIS NOTICE, AND I THAT I HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE CONTENTS OF THIS NOTICE AND ELECT TO ATTEND TREATMENT AT SERENITY LANE.

By signing below, I acknowledge that I still wish to become a patient of Serenity Lane.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Serenity Lane's Privacy Officer at: (541) 284-8605

Serenity Lane
Coburg Campus and Administrative Offices
Physical Address 1 Serenity Lane, Coburg, OR 97408
Mailing Address PO Box 8549, Coburg, OR 97408

WHO WILL FOLLOW THIS NOTICE: This notice describes the information privacy practices followed by Serenity Lane's staff members.

YOUR HEALTH INFORMATION: This notice applies to the information and records we have about your health, health status, and the health care and services you receive at Serenity Lane. Your health information may include information created and received by Serenity Lane and may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The confidentiality of our patients' records is protected by federal law and regulations. Generally, we may not say to persons outside our facilities that a patient attends our facilities, or disclose any information identifying a patient as a person with a substance use disorder unless the patient agrees to the disclosure in writing, the disclosure is allowed by subpoena and court order, or the disclosure is made to medical personnel in a medical emergency or, under certain circumstances, to qualified personnel for research, audit or program evaluation. In other words, we will not disclose drug and alcohol health records in most circumstances without having your written Authorization.

We may use and disclose health information with your Authorization for the following purposes:

For Treatment: We may use health information about you to provide you with clinical treatment or services. We may disclose health information about you to Serenity Lane's doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for chemical dependency and may need to know if you have other health problems that could complicate your treatment. The doctor may use your clinical history to decide what treatment is best for you. With a written authorization, the doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Notice of Privacy Practices (continued)

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your clinical care outside Serenity Lane and may require information about you. This information may be shared with them only with your written authorization.

For payment: We may use and disclose health information about you so that the treatment and services you receive at Serenity Lane may be billed to and payment may be collected from your insurance company, a third party or from you.

For example, we will need to contact your insurance company to determine your eligibility and estimated benefits. We may tell your health plan about a treatment you are going to receive in order to obtain prior approval. Your insurance company may require treatment updates and clinical records to determine whether your plan will pay for treatment.

For Health Care Operations. We may use and disclose health information about you in order to perform business functions and provide quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about you to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage for the purpose of helping these providers and plans provide improved quality of care and improve services, reduce cost, coordinate and manage health care and services, train staff and comply with the legal requirements and accrediting organizations.

We may use your protected health information for purposes of treatment, payment and health care operations to communicate between or among our own staff, facilities, and certain organizations which have a need for the information in connection with their duties or functions related to diagnosing, treating, or referring you for treatment. In these instances, we do not need your written Authorization to make such communications. If, however, we disclose your protected health information for treatment, payment or health care operations to other persons or organizations, we will first need your written Authorization to make such a disclosure.

Appointment Reminders. We may contact you as a reminder that you have an appointment for assessment, treatment or admission at Serenity Lane. For example, we may telephone you at the telephone number you provide or send you a text message reminder. You have the right to opt out of these communications at any time, either by contacting Serenity Lane staff directly or by replying “STOP” to a text message reminder.

Treatment Alternatives; We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. For example, you may have a condition that requires special care. We may recommend a specialist or treatment facility appropriate for your condition.

Notice of Privacy Practices (continued)

Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose your health information for the following purposes, subject to all applicable legal requirements, including the requirement, where applicable, to obtain your written Authorization:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, Serenity Lane will take appropriate actions, including notifying authorities and/or family members, regarding a situation that may place you or someone else in physical danger.

Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

Business Associates. We may disclose your health information to "business associates" with which we contract to perform services on our behalf.

Research. We may use and disclose health information about you for research after determining that the researcher 1) is qualified, 2) has a protocol with appropriate safeguards; and 3) has had independent review by an IRB or similar review board. A limited data set may also be created and used without authorization under specified conditions. For example, we may use your treatment information to determine the effectiveness of a procedure or treatment. We will obtain your authorization if the researcher will have access to your name, address or other information that reveals who you are or the researcher will be involved in your care at Serenity Lane.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may disclose your health information to authorized federal officials for intelligence, counterintelligence, special investigations, and other national security activities authorized by law or to protect the President or other authorized persons.

Workers' Compensation. We may release health information about you for worker's compensation or similar disability programs with your written Authorization.

Incidental Disclosures. Certain incidental disclosures of your health information may occur as a by-product of permitted uses and disclosures. For example, a roommate may inadvertently overhear a discussion about your care if you share a room.

Notice of Privacy Practices (continued)

Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products. Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected by federal substance abuse information confidentiality laws. Medical information may be disclosed to personnel from the Food and Drug Administration (FDA) who believe that your health may be threatened by a product under FDA jurisdiction.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws. For example, the State of Oregon will audit select records to determine Serenity Lane's compliance for licensure.

Fundraising. We may use or disclose to a "business associate" limited information about you to raise money for Serenity Lane. You may opt-out of receiving future communication or materials relating to fundraising.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose treatment information about you with a subpoena and a proper court order or with your written Authorization. Information may be released if you commit a crime on Serenity Lane's premises. Should Serenity Lane feel it necessary to take court action to receive payment for any amount owing, you give permission for your name to be published in any forum legally necessary to proceed with such actions. This means if Serenity Lane, or you, file a court action, your relationship with Serenity Lane may become public record.

Law Enforcement. We may release treatment information if asked to do so by a law enforcement official in response to an appropriate court order and subpoena. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine a cause of death.

Victims of Abuse, Neglect or Domestic Violence. As allowed or required by law, we may disclose health information about an individual we reasonably believe to be the victim of abuse, neglect, or domestic violence to a government authority authorized to receive such reports.

Information Not Personally Identifiable. We may use or disclose treatment information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose treatment information about you to your family members or friends if we obtain your written Authorization to do so.

Notice of Privacy Practices (continued)

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION. We may use or disclose your health information for purposes other than those identified in the previous sections with your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time unless it is a non-revocable criminal justice authorization to release protected health information. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. In some circumstances, we may need specific, written authorization from you in order to disclose certain types of specially–protected information such as HIV, substance use disorder, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU. You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your treatment information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Medical Records Department for Hospital/Residential/Eugene Outpatient Program located downtown Eugene. For Outpatient treatment at other sites, submit request to the Program Manager in order to inspect or to receive copies of your treatment information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe treatment information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for Serenity Lane. To request an amendment, complete and submit a TREATMENT RECORD AMMENDMENT CORRECTION FORM to the Program Manager.

We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that we did not create, the information is not part of the treatment information that Serenity Lane keeps; if it is information that you would not be permitted to inspect and copy; or if it is determined that the information is accurate and complete.

Right to An Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national

Notice of Privacy Practices (continued)

security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made to you or based on your written authorization.

To obtain this list, you must submit your request in writing to Program Manager. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate your mailing address. This first list you request within a 12-month period will be free. For additional lists, we may charge you the normal copy fee of $25.00 per request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the treatment information we use or disclose about you for treatment, payment or health care operations by making selective choices on the written authorization to release such information. You also have the right to request a limit on the treatment information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION to the Program Manager.

Right to Request Confidential Communications. You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION OF USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION form to the Program Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Program Manager.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with Serenity Lane's Privacy Officer, at the address located at the beginning of this form. You may file a complaint to the Secretary of The Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, Room 425A, 200 Independence Avenue, SW, Washington, DC 20201. You will not be penalized for filing a complaint.

See 42 U.S.C. 290-3 and 42 U.S.C.290-3 for federal laws and 42 CFR part 2 for federal regulations protecting the confidentiality of substance abuse information. Violation of these federal laws and regulations by a covered program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Other applicable regulations are found at 45 CFR parts 160 and 164.

SERENITY LANE
Alcohol & Drug Treatment Services

Name:_____ Date: _____

DOB:_____

AUTHORIZATION FOR THE RELEASE OF INFORMATION - EMERGENCY CONTACT ONLY

In the event of an emergency or if I am unable to give authorization due to the severity of my condition, this release allows Serenity Lane to contact my emergency contact listed below. I acknowledge I am responsible for providing any updated emergency contact information to Serenity Lane.

Emergency Contact:

Relationship:

Address:

Primary Phone: Work Phone:

Purpose of Authorization: EMERGENCY CONTACT ONLY

Information to be Released: Information pertaining to the medical emergency or condition.
Expiration of Authorization: Unless revoked before or otherwise limited below, this authorization is valid for two years from the date of signature. Other date or circumstances: [Other date/circumstances: ROIE]

Right of Revocation: I have the right to revoke this authorization at any time. For my protection it is preferable to provide a written request to revoke an authorization. A form is available at all Serenity Lane Offices or I may revoke an authorization by calling any Serenity Lane Office. I understand that revocation of an authorization will not affect any information that was released before I revoked the authorization.

Releasing Records: I understand that the records released may contain substance use disorder treatment information or psychological information. I know that any communication will reveal my presence as a patient at Serenity Lane. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure.

NOTICE: My records are protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit the receiver of this information from disclosing to any other parties information in this record that identifies me as having or having had a substance use disorder either directly, or by reference to other individuals with knowledge about me or by publicly available information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of this information to investigate or prosecute me with regard to a crime except as provided at §§ 2.12(c)(5) and 2.65.

have read the above and understand what this authorization means. I am satisfied with any explanations that I may have requested and received. I approve the release of the information listed above. I understand that treatment is not conditioned on signing this authorization unless treatment is for the purpose of creating health information about me for a third party or for research purposes. A photocopy or a fax copy shall be as valid as the original. I have been given a copy of this authorization.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

SERENITY LANE
Alcohol & Drug Treatment Services

Patient Name:_____ Date: _____

DOB:_____

RELEASE OF INFORMATION (ROI) AUTHORIZATION FOR THE RELEASE OF SUBSTANCE USE DISORDER and MH INFORMATION

I am requesting that Serenity Lane exchange verbal and/or written treatment information about me with:

Facility: _____

Contact Person: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Fax: _____ Phone: _____

Relationship: _____

What information should we share?
Please specify: ☐ Confirmation of Admission ☐ Assessments ☐ Attendance ☐ Dates of Treatment ☐ Diagnosis
☐ History & Physical ☐ Lab Results ☐ Medications ☐ Progress in Treatment ☐ Psychiatric Consultations
☐ Psychological Testing ☐ Toxicology Results
☐ Treatment Recommendations ☐ Discharge Summaries __
Other Information to be released: _____

Release Billing Information? ☐ Yes ☐ No

EXCLUSIONS from Authorization: _____

Purpose of Authorization: ☐ Family Participation ☐ Legal Issues ☐ Employment Issues
☐ Professional Licensure ☐ FMLA Short Term Disability

Blue Flag Monitoring Requested? ☐ Yes ☐ No
Note: Marking yes to Blue Flag Monitoring means we will begin monthly monitoring to the person or agency you identified on this form.

Expiration of Authorization: Unless revoked before or otherwise limited below, this authorization is valid for two years from the date of signature. Other date or circumstances: _____

Right of Revocation: I understand that this authorization may be revoked at any time. For my protection, it is preferable to provide a written request to revoke an authorization. A form is available at all Serenity Lane Offices, or I may also revoke an authorization by calling any Serenity Lane Office. I understand that cancellation of an authorization will not affect any information that was previously released before I revoked the authorization.

Releasing Records: I understand that the records released may contain substance use disorder treatment information or psychological information. I know that any communication will reveal my presence as a patient at Serenity Lane. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure.

AUTHORIZATION FOR THE RELEASE OF SUBSTANCE USE DISORDER and MH INFORMATION (continued)

NOTICE: Patient records are protected by Federal Law 42 C.F.R. Part 2. This Federal Law prohibits the re-disclosure of substance use disorder treatment information without a valid written authorization from the patient to whom it pertains.

I have read the above and understand what this authorization means. I am satisfied with any explanations that I may have requested and received. I approve the release of the information listed above. I understand that treatment is not conditioned on signing this authorization unless treatment is for the purpose of creating health information about me for a third party or for research purposes. A photocopy or a fax copy shall be as valid as the original. I have been given a copy of this authorization.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

SERENITY LANE
Alcohol & Drug Treatment Services

Patient Name:_____ Date: _____

DOB:_____

Patient Primary Care Provider (PCP): _____

Current Mailing Address: _____

Cell: _____ Home: _____ Email: _____

DOB: _____ Patient or Chart ID #: _____

INSTRUCTIONS: At the beginning of treatment, the patient should fill in the rows with their current medication information. Date and sign this entry at the bottom of the page. At the time of review, add any new medications, put a neat line through any medications that have been discontinued. Date and sign each review at the bottom of the page.

Date	Medications	Dose	Reason for Use/Diagnosis

Date	Signature	Date	Signature

SERENITY LANE
Alcohol & Drug Treatment Services

Patient Name:_____ Date: _____

DOB:_____

Patient Preferences & Goals

Instructions for Staff: This packet should replace the Problems and Goals form, and should be filled out prior to starting the Service Plan. The patient's Primary Counselor should review this information and use it in the Service Plan and to determine if any accommodations for patient preferences, disabilities or any other reason should be made. The patient's own words should be used in the Service Plan. The packet should be scanned into imaging and labeled as "Patient Preferences and Goals".

This form is to help Serenity Lane make your goals a priority while you are in our care. We want work to with you throughout treatment to create and update a Service Plan that focuses on helping you with problems you are experiencing as a result of substance use, as well as what you wish to accomplish while you are in our care.

Gender:_____ Gender Identity:_____

Sexual Orientation: _____ Race: _____

Ethnicity: _____ Highest School Grade Completed: _____

Can you read and write English well enough to complete treatment assignments? _____

What language is primarily spoken at home: _____

Please describe your religious/spiritual background, beliefs, and participation:_____

Please describe your values and attitude towards alcohol and drug use:_____

What do we need to understand about your beliefs, culture, or traditions to better help you in treatment?_____

_____

What accommodations would you like to request while receiving treatment at Serenity Lane?_____

_____

Do you have any preferences regarding how we can support you with a disability or disorder? (Ex: A blind person may or may not want

assistance navigating the facility): _____

_____

What things will make you feel better if you are having a hard time?_____

SERENITY LANE
Alcohol & Drug Treatment Services

Patient Name:_____ Date: _____

DOB:_____

SNAP ASSESSMENT

STRENGTHS What personal traits do you have which will help you in treatment?	☐ Open minded ☐ Friendly ☐ Creative ☐ Good Listener ☐ Empathetic ☐ Assertive ☐ Strong personal or spiritual values ☐ Dependable ☐ Can work well with others ☐ Motivated for change ☐ Quick Learner ☐ Organized ☐ Good problem solver ☐ Hard Worker Other _____
NEEDS What do you need to be successful with sobriety?	☐ To learn more about local recovery resources ☐ A sober living environment ☐ Help to reduce chronic pain ☐ Help to stop smoking ☐ More information about my mental health diagnosis ☐ Resources for job training or education ☐ Access to medical care ☐ A safe place to practice new coping skills ☐ To learn how to talk about what concerns me ☐ To learn how to improve sleep ☐ To learn how to reduce anxiety or relax more ☐ To learn how to reduce depression symptoms ☐ To learn healthy ways to express anger ☐ To learn better time management skills ☐ To learn leisure skills ☐ To learn how to challenge my thinking ☐ To learn healthy eating habits Other _____
ABILITIES What skills do you have?	☐ Ability to cooperate with others ☐ Ability to manage my emotions effectively ☐ Ability to make healthy decisions for my life ☐ Ability to have positive relationships with others ☐ Time management skills ☐ Basic ability to read and write ☐ Computer skills ☐ Job skills _____ ☐ Education or Training _____ ☐ Leisure skills_____
PREFERENCES	What services do you want most: ☐ For family or friends to be involved in my treatment ☐ Group Counseling Sessions ☐ One on One sessions ☐ Mental Health counseling ☐ Spiritual Counseling ☐ Alumni information How do you learn best: ☐ Written Assignments ☐ Workbooks ☐ Reading material ☐ Sharing in group ☐ Lectures/Workshop ☐ Creative projects ☐ Hands on experience

SERENITY LANE
Alcohol & Drug Treatment Services

Patient Name:_____ Date: _____

DOB:_____

Problems and Goals

Please take a moment and reflect on your reasons for being here:
What problems/issues or circumstances have led to your admission? What are your hopes/expectations from this treatment experience?
After giving these questions some thought, write down your three highest priority problems/issues. Then, after each problem, write down your goal statement, which should reflect how you would know that your problem has been resolved or significantly reduced. Some problems to consider might be your alcoholism/addiction, anger, legal issues, shame, guilt, communication, relaxation skills, what you will do with your free time since you stopped drinking/using, employment/job issues, spirituality, surrender, acceptance, etc.

Problem I: _____

_____

Goal I: _____

_____

Problem II: _____

_____

Goal II: _____

_____

Problem III: _____

_____

Goal III: _____

_____

What two (2) things are you willing to do to achieve the goals you have listed?

1. _____

2. _____

Your counselor will discuss these issues with you as part of your treatment planning process.