JAMHI'S CONFIDENTIAL INFORMATION AND HEALTH HISTORY FORM

Today's Date:	Date of last physical exam:

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name(s):	Sex at birth: ○ M ○ F

Who is your Primary Care Doctor? Have you received services from JAMHI before?

Social Security Number:	**Emergency Contact (Name, Relation & Phone #)**	
Phone Number (best contact):	**Phone Type (home, work, cell):**	**Preferred Method of Contact (mail, phone, email):**
Email Address:	**Insurance Name/ID#:**	
Physical Address (city, state, zip):	**Mailing Address (city, state, zip):**	

Preferred Language if other than English:

Race: mark an (x) next to appropriate answer:

- ○ **Asian**
- ○ **Native Hawaiian**
- ○ **Other Pacific Islander**
- ○ **Black/African American**
- ○ **American Indian/Alaska Native**
- ○ **White**
- ○ **More than one race**
- ○ **Refuse to answer**

Ethnicity:

- ○ **Hispanic/Latino**
- ○ **Non-Hispanic/Latino**
- ○ **Refuse to answer**

Sexual Orientation:

- ○ **Straight (not lesbian or gay)**
- ○ **Lesbian or Gay**
- ○ **Bisexual**
- ○ **Something Else**
- ○ **Don't Know**
- ○ **Choose not to Disclose**

What gender do you currently identify as (mark (x) next to appropriate answer):

- ○ **Male**
- ○ **Female**
- ○ **Transgender Male/female to male**
- ○ **Transgender Female/male to female**
- ○ **Something Else**
- ○ **Choose not to Disclose**

Please describe your living arrangements. Do you rent or own your home:_____

_____

_____

Do you live in public housing:

○ Yes ○ No

Current household income:

- ○ **Monthly - $**_____
- ○ **Annual - $** _____

# of Children: _____

Total # of People in Household: _____

Highest Level of Education: _____

Marital Status: _____

SOCIAL HISTORY (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

Do you currently use tobacco products? ___Yes ___No. If yes, How much per day/week? _____

If yes, how many years have you used tobacco products? _____Years. Are you interested in quitting? ___ Yes ___ No.

If you used tobacco in the past, how long have you been quit? _____. How long did you smoke/chew? _____Years.

Do you drink alcohol? ___Yes ___No. If yes, How many drinks per day? ___ per week?____

Do you use marijuana products? Including edibles, vape pens, tinctures, oils, etc. ___Yes ___ No.

If yes, what type(s)? _____ How much per day/week?_____

Do you currently use any recreational drugs? ___Yes ___No. If yes, which ones? _____

Last date of recreational use & drugs of choice:_____

Have you used recreation drugs in the past? ___Yes ___No. If yes, which ones? _____

How long has it been since you quit? _____

FAMILY HISTORY (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

What health conditions run in your family? (Biological Family)

Mother:	**Father:**
Maternal Grandmother:	**Paternal Grandmother:**
Maternal Grandfather:	**Paternal Grandfather:**
Other close family members including siblings, aunts, uncles and children (Please specify what and whom):	

MEDICAL HISTORY (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

SURGICAL HISTORY: Please provide a brief description below

Operation:	Year:	Hospital:
Operation:	Year:	Hospital:
Operation:	Year:	Hospital:

NON-Surgical Hospitalization/Serious Injuries (please detail year and problem):

MEDICATIONS (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

List all medications you are currently taking including non-prescription drugs (include dosage and frequency taken):

Med:	Dose:	Frequency:
Med:	Dose:	Frequency:
Med:	Dose:	Frequency:
Med:	Dose:	Frequency:

ALLERGIES (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

List all allergies and the type of allergic reaction experienced you may have to medication/food/environment:

Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:

CURRENT SYMPTOMS (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

Check (X) next to the symptoms you currently have or have had ***in the last month***:

General:	**Gastrointestinal**	**Cardiovascular:**	**Genito-Urinary**
○ Fever or chills ○ Loss of sleep ○ Sweats ○ Persistent Cough ○ Shortness of Breath ○ Nervousness ○ Anxiety ○ Depression ○ Suicidal Ideation	○ Poor appetite ○ Bowel changes ○ Constipation ○ Diarrhea ○ Indigestion ○ Nausea ○ Stomach Pain ○ Vomiting ○ Heartburn ○ Extreme weight loss/ weight gain	○ Chest pain ○ Chest Pressure ○ High Blood Pressure ○ Irregular Heartbeat ○ Poor Circulation ○ Rapid Heartbeat ○ Swelling of the ankles ○ Varicose Veins	○ Blood in urine ○ Frequent urination ○ Lack of bladder control ○ Painful urination ○ Urine retention ○ Abnormal genital discharge ○ Pain during intercourse
Eyes, ears, nose, throat:	**Muscle & Joint Pain**	**Skin**	**Neurological**
○ Blurred vision ○ Double vision ○ Loss of hearing ○ Ringing in ears ○ Sinus pain or congestions ○ Sore Throat ○ Difficulty swallowing	○ Arms ○ Back ○ Feet ○ Hands ○ Hips ○ Legs ○ Neck ○ Shoulders	○ Bruise easily ○ Rashes ○ Lumps ○ Bumps ○ Abnormal Moles	○ Headaches ○ Numbness or Tingling ○ Weakness ○ Poor Balance ○ Tremor ○ Seizure like activity ○ Dizziness ○ Fainting

Over the past 2 weeks, how often have you been bothered by any of the following?	Not at all	Several Days	More than Half	Almost All
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PAST MEDICAL HISTORY (IF YOU REQUIRE MORE SPACE, PLEASE USE BACK OF PAGE)

Check (X) next to the conditions you have had ***in your lifetime***:

○ **AIDS**	○ **Cancer**	○ **Herpes**	○ **Rheumatic fever**
○ **Alcoholism**	○ **Diabetes**	○ **High Blood Pressure**	○ **Stroke**
○ **Anemia**	○ **Emphysema**	○ **HIV positive**	○ **Suicide attempt**
○ **Arthritis**	○ **Epilepsy**	○ **Kidney disease**	○ **STDs**
○ **Asthma**	○ **Gout**	○ **Liver disease**	○ **Tuberculosis**
○ **Bleeding disorders**	○ **Heart disease**	○ **Pneumonia**	○ **Ulcers**
○ **Bronchitis**	○ **Hepatitis**	○ **Psychiatric care**	

Please provide any further information you feel is important to add to your confidential medical profile in this space provided here:

***By signing this form, I acknowledge receipt of the No Show policy and consent for treatment.**

_____ _____

Patient Signature (Or Name & Signature of Legal Guardian) Date

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Financial Responsibility

- ✓ JAMHI offers a sliding fee scale discount to income eligible clients for all services

By Accepting services at JAMHI Health & Wellness, Inc.:

- I accept financial responsibility for keeping my account current
- Payment is due in full at the time services are rendered unless other mutually agreed upon arrangements are made with JAMHI Health & Wellness, Inc in advance of services.
- It is my responsibility to inform JAMHI of any changes in my financial status.
- I am responsible for providing a Medicaid eligibility card.
- I am aware that I must provide accurate billing information. Failure to do so may result in surcharges for retroactive billing and processing being applied to my account.
- My financial records may be released to a collection agency if my account becomes delinquent.
- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill or the portion not covered by my insurance company.
- I authorize JAMHI to act as my agent in helping me obtain payment from my insurance company.
- I authorize direct payment to JAMHI.
- I permit a copy of this authorization to be used in place of the original.
- I certify that I have been advised of and had explained to me JAMHI's package of services.

Client Signature _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

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What is JAMHI Health and Wellness?

JAMHI Health and Wellness (JAMHI) provides services for persons experiencing substance use, mental health and behavioral disorders, traumatic brain injury and developmental disabilities. In addition, we provide primary care treatment, wellness activities and pharmacy services.

Statement of Client Rights and Responsibilities

Your treatment and care is individualized and specific to you. We provide services in a welcoming, comprehensive, accessible manner to best meet your needs and consider you to be a valued member of your treatment team.

As a JAMHI client, I have a right to:

Basic Rights

- Be treated with respect and dignity.
- Receive services specific to me and my life.
- Be heard.
- Be safe.
- Participate in developing, reviewing and updating my treatment plan.
- View my client record, get a copy of my client record or have a copy of my client record sent directly to a third party within a reasonable timeframe.
- Receive information I need to make choices about services and programs available to me within the community and how to access those services.
- File a grievance if I feel I have been treated unfairly.
- Have rules, regulations, and information about my treatment explained in a way that I can understand.

Confidentiality

- Have all information about me handled confidentially. Exception: Information may be disclosed without consent under the following situations:
  - Known or suspected child abuse or neglect
  - Intent to commit suicide or homicide including warning of potential victim(s)
  - A medical or psychiatric emergency
  - To report a crime committed on JAMHI property or against JAMHI staff
  - If JAMHI receives a special court order requiring release
- Have my personal information shared only with those who need to know.

Consent for Sharing Your Information

- Sign a Release of Information form (ROI) so JAMHI can get or share information about me to assist in my treatment.
- Revoke the ROI if I choose to stop sharing information.

Care and Treatment

- Have access and referral to guardians, self-help groups, advocacy services, and legal services when available and necessary.
- Receive information about (including possible side effects) medications prescribed for me.
- Receive an explanation of charges and billings.
- Request a written summary of my treatment that includes discharge and transition plans.

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As a JAMHI client my responsibilities are to:

- Actively participate in treatment including reviewing my treatment plan periodically (usually every 120 days).
- Inform staff of emotions, events, or commitments which may impact treatment.
- Maintain the confidentiality of other clients I may see at JAMHI facilities and activities.
- Be on time for appointments and give 24-hour notice if I cannot make an appointment.
- Provide health insurance information or financial information so JAMHI can determine if I qualify for reduced payment rates. If I choose not to provide this information, I will be responsible for payment of the full amount of services received.
- Appropriately communicate the needs I have while keeping myself and others safe.
- ***Understand that violence, threats, or verbal abuse are not tolerated and may result in discharge from JAMHI services.***

Signature

I have read, understand, and agree to the above statements.

Client Signature _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

JAMHI Health & Wellness, Inc. Policy Manual

Section: **Primary Care**
Policy Number: **PC-6**

SUBJECT: **Appointment Attendance – No Show**

PURPOSE: To outline expectations for patient attendance at scheduled appointments.

POLICY: It is JAMHI Health & Wellness (JAMHI) policy to adhere to consistent protocol to deal with individuals who fail to attend scheduled appointments whether through not showing up, cancelling without proper notice or arriving too late to be seen. Regular attendance at scheduled appointments is crucial for successful treatment. Additionally, missed appointments complicate access to the clinic for others. JAMHI makes every effort to work with individuals to schedule appointments on days and times that are convenient for them to attend and makes every effort to remind people of their appointments.

PROCEDURES:

1. JAMHI requires a minimum notice of 24 hours prior to any cancelled primary care appointment, regardless of appointment type. This allows time to fill the appointment slot to maximize access to services.
2. When an individual fails to provide 24 hours' notice prior to missing a scheduled appointment, which includes no-showing, late notice, or late arrival (10+ minutes), the appointment will be considered a no-show and documented as such.
3. If a patient who has no-showed is in need of medication refills, the prescriber can authorize a short-term refill to get the patient to a confirmed, rescheduled appointment date. This does not apply to patients with active Medication Management Agreements for controlled medications.
4. Patients who no-show must wait a minimum of 3 business days before they can have a rescheduled appointment. The reschedule appointment time will depend on provider availability and may not be during "prime time" appointment time slots. Patients who no-show a second time must wait a minimum of 7 business days before a rescheduled appointment. Patients who no-show a 3rd time will undergo a review by the primary care staff to determine the next step.

Accepted and approved: June 4, 2019

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Notice of Privacy Practices to JAMHI Clients

This notice describes how medical, drug, and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by three federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HITECH Act, 42 U.S.C. §1320d *et seq*., 45 CFR Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 CFR, Part 2. Under these laws, JAMHI may not disclose: 1) that you are a client to any person outside JAMHI, 2) any information identifying you as an alcohol or drug client, or 3) any other protected information except as permitted by federal law.

JAMHI must obtain your written consent before it can disclose information about you for payment purposes. For example, JAMHI must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. A client has the right to request the restriction of disclosure of PHI to a health plan or other party, when the PHI relates solely to a healthcare item, or the client self pays, or another person on behalf of such individual (other than a health plan) has paid JAMHI for services. JAMHI is not required to agree to any restrictions you request, but if it does agree to them it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical/psychiatric emergency.

Generally, you must also sign a written consent before JAMHI can share information for treatment purposes or for health care operations. However, federal law permits JAMHI to disclose information *without* your written permission:

- Pursuant to an agreement with a qualified service organization/business associate;
- For audit and evaluations
- To report a crime committed on JAMHI premises or against JAMHI personnel
- To medical personnel in a medical/psychiatric emergency
- To appropriate authorities to report suspected child abuse or neglect
- As allowed by a court order

Before JAMHI can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Your Rights

- You have the right to request a copy of your record by hard copy, fax or electronic media *except* under conditions listed below.
- Your authorization is required and that authorization may be revoked for 1) uses and disclosures of PHI for marketing purposes, 2) disclosure that constitutes a sale of PHI, 3) any use or disclosure other than those contained in this notice and 4) fundraising purposes. The uses and disclosures noted above are in the law but JAMHI does not engage in these practices.
- You have the right to request that we communicate with you by alternative means or at an alternate location. JAMHI will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA and HITECH you also have the right to inspect and copy your own health information maintained by JAMHI, *except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances.*
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained by JAMHI's records, and request and receive an accounting of disclosures of your health related information made by JAMHI during the seven years prior to your request. You also have a right to receive a paper copy of this notice.

JAMHI's Duties

JAMHI is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. JAMHI is required by law to abide by the terms of this notice. JAMHI reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. JAMHI is required to notify clients whose PHI has been involved in a breach.

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Complaints and Reporting Violations

You may complain to JAMHI and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You will not be retaliated against for filing such a complaint. The following name, address, and phone numbers are who you can make the report to:

Privacy Officer
3406 Glacier Hwy
Juneau, AK 99801
907-463-3303

Office for Civil Rights Department of Health and Human Services
Attn: Patient Safety Act
200 Independence Ave., SW, Rm. 509F
Washington, DC 20201
202-619-0403

For further information contact the Privacy Officer at JAMHI at the following address and/or phone number:

Privacy Officer
3406 Glacier Hwy
Juneau, AK 99801
907-463-3303

Acknowledgement

I hereby acknowledge that I received a copy of this notice.

Client Signature _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____