MultiCare
BetterConnected
Behavioral Health

Thank you for choosing MultiCare Behavioral Health.

Please print out this complete packet, fill out all the pages **no more than 5-days prior,** sign and date where appropriate. Bring these with you to your assessment along with your identification and insurance information.

If you are not able to bring this paperwork, please check in for your assessment **30-minutes prior** to your appointment to allow enough time to complete the paperwork before you are seen.

MultiCare Behavioral Health
BetterConnected

Welcome to MultiCare Behavioral Health

Please select *ALL* that apply related to why you (or your child) are/is seeking services:

I (or my child) am/is here today in need of…

- ☐ ADHD Evaluation
- ☐ Anger Management
- ☐ Assistance in Completion of Documentation (i.e. Social Security, FMLA, etc.)
- ☐ Autism Evaluation
- ☐ Bariatric surgery – Weight loss counseling
- ☐ Continued benefits
- ☐ Counseling/Talk therapy
- ☐ Counseling and Psychiatric Medication Services
- ☐ Court Ordered Assessment
- ☐ Custody/Parenting Evaluation
- ☐ Mental Health Evaluation Only
- ☐ Housing Resources
- ☐ I'm not sure, my doctor told me I needed to
- ☐ I'm not sure, my family told me I needed to
- ☐ Job Resources
- ☐ Parenting Support
- ☐ Psychiatric Medication Prescription
- ☐ Release to Return to School/Work
- ☐ Gambling Issues
- ☐ Food Addiction
- ☐ Couples Counseling
- ☐ Other:

I (or my child) am/is experiencing…

- ☐ Anger Issues
- ☐ Anxious feelings
- ☐ Behavior problems
- ☐ Depression
- ☐ Domestic Violence
- ☐ Hearing voices
- ☐ Isolation – I want to be alone all the time
- ☐ Mood changes
- ☐ Paranoia
- ☐ Sadness over a death or other loss
- ☐ Seeing things other people aren't
- ☐ Substance Use concern
- ☐ Thoughts to harm myself
- ☐ Thoughts to harm other people
- ☐ Trauma

How long do you anticipate being in treatment? (Check one)

- ☐ 6 months
- ☐ 6-12 months
- ☐ 12+ months

Often during treatment, you might be asked to practice new skills outside of the therapy room. How comfortable do you feel doing that?

- ☐ Very comfortable
- ☐ Somewhat comfortable
- ☐ Not comfortable

What barriers/challenges might prevent you from making the most out of therapy?

- ☐ Transportation issues
- ☐ No child-care
- ☐ Stress of waiting in the lobby
- ☐ Other: _____

Client Name: First MI Last	**DOB:**	**Date:**
Client Identified Needs Prior to Assessment	**Client ID #:**	

MultiCare Behavioral Health
BetterConnected

325 East Pioneer Ave, Puyallup, WA 98372
Phone: 253.697.8400

CONSENT TO RECEIVE SERVICES: I agree to care and treatment by MultiCare Behavioral Health (MBH). MBH provides services to individuals who have emotional, behavioral, psychiatric, and substance abuse problems. These services include but are not limited to assessment of needs, individual/family/group therapy for adults and children, case management and in some cases medical treatment through the use of medications. I understand I have the right to ask questions about my care at any time, and to be involved in my care decisions. My signature below indicates my consent for treatment as offered by MultiCare Behavioral Health.

PHONE, EMAIL, TEXT MESSAGING AUTHORIZATIONS: I grant permission and consent to MultiCare: (1) to contact me by phone at any phone number associated with me, including wireless (cell) numbers; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (3) to send me text messages or emails using any email or cellular device addresses I provide and; (4) to use pre-recorded/artificial voice messages and/or and automatic dialing device (an "autodialer")in connection with any communications made to me or related to my scheduled services and my account.

CONFIDENTIALITY AND RELEASE OF INFORMATION: I understand that my records are protected under Washington State Law RCW 70.02 and by HIPAA Federal Regulations 45 CFR, Parts, 160 and 164 as well as Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2. Multicare Behavioral Health will disclose health care information *without* the client's authorization only to the extent required by law.

When family therapy is provided, the Client (aged 13 or over) or their parent/legal guardian (when under 13) will sign a Release of Information Authorization form on behalf of all participants in the therapy sessions. Confidential information will only be released in accordance with federal (42 CFR, Part 2 and HIPAA 45 CFR, Parts 160 and 164) and state (RCW 70.02) laws regarding disclosure of health information. Sensitive information regarding family members' mental health, chemical dependency and/or sexually transmitted disease will be reviewed for redaction before release.

I have carefully read and understand all of the above categories and have received a copy of this form as attested to by my signature below.

Client Signature (Required age 13 and older): _____

Responsible Party Parent/Legal Guardian Signature: _____

Client Name: First MI Last	Client ID #:
Admission and Consent for Treatment	Date:

MultiCare Behavioral Health
BetterConnected

325 E. Pioneer Ave.
Puyallup, WA 98372
253-697-8400

FINANCIAL AGREEMENT: I agree to pay MultiCare Behavioral Health (MBH) for care at regular rates and terms. I permit MBH to appeal any denial received from my insurance company. If a third party payor will not pay, I agree to pay for the services given. If my bill is sent to a lawyer or collection agency, I will pay all reasonable fees. I have the right to refuse to provide financial information. If I choose to do this, I understand I will be liable for the full cost of services received.

THIRD PARTY INSURANCE: In the event that my third party carrier has a contractual relationship with Multicare Behavioral Health, the portion of the fee that is my responsibility may vary from the fee schedule. I am responsible for meeting my deductible and understand that any co-payment fees are due and payable at the time service is rendered. I have been notified that my third party carrier/Medicare could deny payment for some services. I understand that I am financially responsible to pay for services not covered by my third party carrier/Medicare. I understand that it is my responsibility to know and follow my third party company's referral and authorization process, which could include obtaining a written referral from my Primary Care Physician or preauthorization from my third party company.

MEDICAID BENEFITS: I understand that I may be asked to provide my DSHS Provider One card for each service I receive at Multicare Behavioral Health. If my Medicaid funds are terminated I will contact Multicare Behavioral Health at once.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits from all third party companies including Medicare and Medicaid to be made directly to Multicare Behavioral Health for services received at all facilities. I have received a copy of the MBH No Show Policy, and I understand that I may be charged a fee for no-shows or cancellations of appointments unless I notify Multicare Behavioral Health 24 hours in advance.

RELEASE OF INFORMATION: I hereby authorize the use and release of any medical or psychiatric healthcare information necessary to process all third party claims and public assistance billings. This information could include my name (or my guardian's name), address, date of birth, admission and discharge dates, telephone numbers, social security number, medical records, account numbers and charges at MBH.

In the event I pursue insurance coverage through the Washington Health Plan Finder, I give permission for MultiCare Behavioral Health's Certified Application Counselor to Partner with my application for any questions or assistance in regards to my insurance

I understand that my signature upon this document shall be treated as a contract. If the terms of this contract are not met then the contract shall be considered in default and my account may be referred to an attorney or a collection agency whereupon I agree to pay all court costs and attorney fees.

I have carefully read and understand all of the information above as attested to by my signature.

Client Signature (Required age 13 and older):_____
Responsible Party Parent/Legal Guardian Signature:_____
Print Responsible Party Name:_____
Address if different from Client:_____

Client Name: First MI Last	Client ID #:
Financial Information Contract	**Date:**

MultiCare Behavioral Health
Client Rights and Responsibilities

Client Rights: *As a client of MultiCare Behavioral Health (MBH), you have the right to:*

- Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
- Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
- Be free of any sexual harassment;
- Be free of exploitation, including physical and financial exploitation;
- Have all clinical and personal information treated in accordance with state and federal confidentiality regulations;
- Participate in planning of your own health care and treatment that considers your own medical and/or mental health advance directive;
- Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections and have a copy of your record;
- Receive a copy of agency complaint and grievance procedures upon request and to lodge a complaint or grievance with the agency, or Behavioral Health Organization (BHO), if applicable, if you believe your rights have been violated; and file a complaint with the department when you feel the agency has violated a WAC requirement regulating behavioral health agencies;
- Develop, understand the available treatment options and alternatives, and participate in the decisions for a plan of care and services which meets your unique needs;
- Receive an explanation of all medications prescribed, including expected effect and possible side effects.
- You have the right to contact the Washington State Department of Health if you believe your counselor exhibits unprofessional conduct as described in RCW 18.130.180. Washington State Department of Health, Health Systems Quality Assurance, Complaint Intake, P.O. Box 47857, Olympia, WA 98504-7857 or 360.236.4700.

Client Responsibilities: *As a client of MultiCare Behavioral Health (MBH), you have the responsibility to:*

- Provide MBH with a completed and accurate health history;
- Provide MBH with all requested insurance and financial information, as well as updates in insurance and financial status;
- Participate in your care by asking questions and expressing concerns;
- Treat MBH personnel, other clients, and property with respect and consideration. Assaults upon health care workers are a felony;
- Notify MBH staff of appointment cancellations at least 24 hours in advance. Be on time for appointments;
- Refrain from using profanity in the common areas of the facility;
- Bring no weapons onto the MBH grounds or into the facility;
- Maintain supervision of your children in the waiting areas or make arrangements for their supervision. Do not leave children unattended.

* _____ * _____

Client signature (*required age 13 and older*): date

* _____ * _____

Responsible Party / Parent / Legal Guardian signature: date

Client Name: First MI Last	Client ID#:
Client Rights	Date:

If you are enrolled with Medicaid in Washington State you have the right:

- To be treated with dignity and respect;
- To have your privacy protected;
- To help develop a plan of care with services to meet your needs;
- To participate in decisions regarding your mental health care;
- To receive services in a barrier-free location (accessible);
- To request information about names, location, phones, and languages for local agencies;
- To receive the amount and duration of services you need;
- To request information about the structure and operation of the BHO;
- To services within two hours for emergent care and 24 hours for urgent care;
- To be free from use of seclusion or restraints;
- To receive age and culturally appropriate services;
- To be provided a certified interpreter and translated material at no cost to you;
- To understand available treatment options and alternatives;
- To refuse any proposed treatment;
- To receive care that does not discriminate against you (e.g. age, race, type of illness);
- To be free of any sexual exploitation or harassment;
- To receive an explanation of all medications prescribed and possible side effects;
- To make an advance directive that states your choices and preferences for mental health care;
- To receive quality services which are medically necessary;
- To have a second opinion from a mental health professional;
- File a grievance, file an appeal on a Notice of Action, or request an administrative fair hearing;
- To choose a mental health care provider or choose one for your child who is under 13 years of age;
- To change mental health care providers during the first 30 days, and sometimes more often;
- To request and receive a copy of your medical records and ask for changes. You will be told the cost for copying;
- Be free from retaliation;
- Request and receive policies and procedures of the BHO and Community Mental Health Agencies (CMHAs) as they pertain to your rights;

Additional Rights for Consumers who have a Less Restrictive Alternative (LRA) or Conditional Release Court Order:

- To receive adequate care and individualized treatment.
- To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that you have the right to attend;
- To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder.
- Of access to attorneys, courts, and other legal redress.
- To have the right to be told that statements you make may be used in the involuntary proceedings.
- To have the right to have all information and records compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapters 70.02, 71.05 and 71.34 RCW.

Additional Client Rights for Residential Treatment Facility (RTF):

- Be free of abuse, including being deprived of food, clothes or other basic necessities;
- Be free of restraint and/or seclusion, except as provided in WAC 246-337-110;
- Participate or abstain from social and religious activities;
- Participate in planning his or her own health care and treatment that considers their own medical and/or mental health advance directives;
- Refuse to perform services for the benefit of the RTF unless agreed to by the resident, as part of the individual healthcare plan and in accordance with applicable law;
- Be informed of the cost of your treatment;
- Have a healthy, safe, clean and comfortable environment;
- Comply with reporting requirements of child or adult abuse and neglect in accordance with chapters 26.44 and 74. RCW;
- Have personal funds protected in accordance with RCW 70.129.040;
- Request an accounting for resident's assets, including allowance, earnings from federal or state sources and expenditures;
- Receive assistance upon request in sending written communications of the fact of the resident's commitment in the RTF to friends, relatives or other persons.
- File a complaint with the Department of Health if the RTF does not follow the standards for RTFs as described in WAC Chapter 246-377: HSQA Complaint Intake; P.O. Box 47857; Olympia WA 98504-7857 or 1.800.633.6828.

Client Name: First MI Last	Client ID#:
Client Rights	Date:

MultiCare Behavioral Health
BetterConnected

MultiCare Behavioral Health
Acknowledgement of Receipt of
Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 253.697.8400, or on this Organization's website at www.multicare.org, or by requesting one at the Organization's offices.

_____ _____

(Date) (Signature**)

_____

(Client's printed name)

**As the parent/guardian/representative of the above individual, I acknowledge receipt of the Notice of Privacy Practices on his or her behalf.

_____ _____

(Signature) (Relationship)

_____ _____

(Printed name) (Date)

Client Name: First MI Last	Client ID #:
Acknowledgement of Receipt of Notice of Privacy Practices	**Date:**

MultiCare

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✔" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself; think that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself in some way	0	1	2	3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult _____
Add Columns		+	+	+
			TOTAL	

(Health care professional: For interpretation of TOTAL, please refer to accompanying scoring card).

Client Name: First MI Last Client ID #:

PHQ-9 **Date:**

Child and Adolescent Trauma Screen (CATS)
Caregiver Report (Ages 7–17 years)

Caregiver's Name: _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark *YES,* if it happened to the child to the best of your knowledge. Mark *No,* if it didn't happen to the child.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. ☐ Yes ☐ No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury. ☐ Yes ☐ No
3. Robbed by threat, force or weapon. ☐ Yes ☐ No
4. Slapped, punched, or beat up by someone in the family. ☐ Yes ☐ No
5. Slapped, punched, or beat up by someone not in the family. ☐ Yes ☐ No
6. Seeing someone in the family get slapped, punched or beat up. ☐ Yes ☐ No
7. Seeing someone in the community get slapped, punched or beat up. ☐ Yes ☐ No
8. Someone older touching his/her private parts when they shouldn't. ☐ Yes ☐ No
9. Someone forcing or pressuring sex, or when he/she couldn't say no. ☐ Yes ☐ No
10. Someone close to the child dying suddenly or violently. ☐ Yes ☐ No
11. Attacked, stabbed, shot at or hurt badly. ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. ☐ Yes ☐ No
13. Stressful or scary medical procedure. ☐ Yes ☐ No
14. Being around war. ☐ Yes ☐ No
15. Other stressful or scary event? ☐ Yes ☐ No
    Describe: _____

**** Which one is bothering the child most now?**

_____

If you answered **YES to any stressful or scary events for the child, then turn the page and answer the next questions.

Child and Adolescent Trauma Screen (CATS)
Caregiver Report (Ages 7—17 years)

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks:

0 – Never 1—Once in a while 2—Half the time 3—Almost Always

1.	Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2.	Bad dreams related to a stressful event.	0	1	2	3
3.	Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4.	Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5.	Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6.	Trying not to remember, talk about or have feelings about a stressful event.	0	1	2	3
7.	Avoiding activities, people, places or things that are reminders of a stressful event.	0	1	2	3
8.	Not being able to remember an important part of a stressful event.	0	1	2	3
9.	Negative changes in how he/she thinks about self, others or the world after a stressful event.	0	1	2	3
10.	Thinking a stressful event happened because he/she or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11.	Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12.	Losing interest in activities he/she enjoyed before a stressful event. Including not playing as much.	0	1	2	3
13.	Feeling distant or cut off from people around her/him.	0	1	2	3
14.	Not showing or reduced positive feelings (being happy, having loving feelings).	0	1	2	3
15.	Being irritable. Or having angry outburst without a good reason and taking it out on other people or things.	0	1	2	3
16.	Risky behavior or behavior that could be harmful.	0	1	2	3
17.	Being overly alert or on guard.	0	1	2	3
18.	Being jumpy or easily startled.	0	1	2	3
19.	Problems with concentration.	0	1	2	3
20.	Trouble falling or staying asleep	0	1	2	3

Total Score_____
Clinical = 15+

Please mark YES or NO if the problems you marked interfered with:

1.	Getting along with others	**____Yes**	**____No**	4.	Family relationships	**____Yes**	**____No**
2.	Hobbies/Fun	**____Yes**	**____No**	5.	General happiness	**____Yes**	**____No**
3.	School or work	**____Yes**	**____No**				

Client Name: First MI Last	Client ID #:
Child and Adolescent Trauma Screen (CATS) **Caregiver Report (Ages 7—17 years)**	**Date:**

Child and Adolescent Trauma Screen (CATS)
Youth Report

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark *YES*, if it happened to you. Mark *No,* if it didn't happen to you.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	□ Yes □ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	□ Yes □ No
3.	Robbed by threat, force or weapon.	□ Yes □ No
4.	Slapped, punched, or beat up by someone in your family.	□ Yes □ No
5.	Slapped, punched, or beat up by someone not in your family.	□ Yes □ No
6.	Seeing someone in your family get slapped, punched or beat up.	□ Yes □ No
7.	Seeing someone in the community get slapped, punched or beat up.	□ Yes □ No
8.	Someone older touching your private parts when they shouldn't.	□ Yes □ No
9.	Someone forcing or pressuring sex, or when you couldn't say no.	□ Yes □ No
10.	Someone close to you dying suddenly or violently.	□ Yes □ No
11.	Attacked, stabbed, shot at or hurt badly.	□ Yes □ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed.	□ Yes □ No
13.	Stressful or scary medical procedure.	□ Yes □ No
14.	Being around war.	□ Yes □ No
15.	Other stressful or scary event?	□ Yes □ No

Describe: _____

**** Which one is bothering you the most now?**
_____

If you answered **YES to any stressful or scary events, then turn the page and answer the next questions.

Child and Adolescent Trauma Screen (CATS)
Youth Report

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

0 – Never 1—Once in a while 2—Half the time 3—Almost Always

1.	Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2.	Bad dreams reminding you of what happened.	0	1	2	3
3.	Feeling as if what happened is happening all over again.	0	1	2	3
4.	Feeling very upset when you are reminded of what happened.	0	1	2	3
5.	Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6.	Trying not to think about or talk about what happened. Or to not have feelings about it.	0	1	2	3
7.	Staying away from people, places, things, or situations that remind you of what happened.	0	1	2	3
8.	Not being able to remember part of what happened.	0	1	2	3
9.	Negative thoughts about yourself or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe.	0	1	2	3
10.	Blaming yourself for what happened, or blaming someone else when it isn't their fault.	0	1	2	3
11.	Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12.	Not wanting to do things you used to do.	0	1	2	3
13.	Not feeling close to people.	0	1	2	3
14.	Not being able to have good or happy feelings.	0	1	2	3
15.	Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16.	Doing unsafe things.	0	1	2	3
17.	Being overly careful or on guard (checking to see who is around you).	0	1	2	3
18.	Being jumpy.	0	1	2	3
19.	Problems paying attention.	0	1	2	3
20.	Trouble falling or staying asleep.	0	1	2	3

Total Score _____
Clinical = 15+

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others ___**Yes** ___**No**
2. Hobbies/Fun ___**Yes** ___**No**
3. School or work ___**Yes** ___**No**
4. Family relationships ___**Yes** ___**No**
5. General happiness ___**Yes** ___**No**

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES
Mental Health Division

MENTAL HEALTH DIVISION

GAIN-SS FORM
[Global Appraisal of Individual Needs-Short Screener]

Section completed by clinician
subscales: 2 or 2 + 2 = COD ASMT

Location of screen:
- ☐ Intake/Admission
- ☐ Tx Plan Session
- ☐ Crisis Episode

Consumer:
- ☐ Declined
- ☐ Unable to complete

To be completed by consumer

By answering the questions in this checklist, you will help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community.
Completing the checklist is optional. If you are willing to answer the questions, please complete the survey and sign your name at the bottom of this page. If you do not wish to answer the questions, please tell your treatment provider and give the checklist back to your treatment provider.

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant: when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

During the past 12 months, have you had significant problems. . .

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	☐ yes	☐ no
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	☐ yes	☐ no
c. feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	☐ yes	☐ no
d. when something reminded you of the past, you became very distressed and upset?	☐ yes	☐ no
e. with thinking about ending your life or committing suicide?	☐ yes	☐ no

IDS Sub-scale Score (0 to 5) ☐

During the past 12 months, did you do the following things two or more times?

a. lie or con to get things you wanted or to avoid having to do something?	☐ yes	☐ no
b. have a hard time paying attention at school, work or home?	☐ yes	☐ no
c. have a hard time listening to instructions at school, work or home?	☐ yes	☐ no
d. been a bully or threatened other people?	☐ yes	☐ no
e. start fights with other people?	☐ yes	☐ no

EDS Sub-scale Score (0 to 5) ☐

During the past 12 months did you. . .

a. use alcohol or drugs weekly?	☐ yes	☐ no
b. spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	☐ yes	☐ no
c. keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	☐ yes	☐ no
d. use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	☐ yes	☐ no
e. have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, use any alcohol or drugs to stop being sick or avoid withdrawal problems?	☐ yes	☐ no

SDS Sub-scale Score (0 to 5) ☐

Client signature _____ *date* _____

Modality: COD SCR Duration: 5 min *(unless otherwise*

 Revised 12/14/06

Client Name:	Client ID #	Client DOB	Gender (circle)
			male female

GAIN–SS | Date

Generalized Anxiety Disorder Scale (GAD7)

Over the last two weeks, how often have you been bothered by any of the following problems?				
	Not at all	**Several days**	**More then half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add Columns	+	+	+	
TOTAL: (*Healthcare professional: for interpretation of TOTAL, please refer to accompanying scoring card)*				

Client Name: First MI Last	Client ID#:
GAD7	**Date**

PSC17—Caregiver Completed (4-18 years)

INSTRUCTIONS: This form asks questions about your child's behavior. These behaviors may be true for every child at sometime in his or her life. Please read each question carefully and check off the box for the responses that you believe is most true for your child during the past **6 MONTHS.**

	Please mark under the heading that best fits your child			*For Office Use*		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Fidget, is unable to sit still.	☐	☐	☐			
2. Act as if driven by a motor.	☐	☐	☐			
3. Daydream too much.	☐	☐	☐			
4. Distract easily.	☐	☐	☐			
5. Feel sad.	☐	☐	☐			
6. Feel hopeless.	☐	☐	☐			
7. Have trouble concentrating.	☐	☐	☐			
8. Fight with other children.	☐	☐	☐			
9. Feel down on him/herself.	☐	☐	☐			
10. Worry a lot.	☐	☐	☐			
11. Seem to be having less fun.	☐	☐	☐			
12. Not listen to rules.	☐	☐	☐			
13. Not understand other people's feelings.	☐	☐	☐			
14. Tease others.	☐	☐	☐			
15. Blame others for his/her troubles.	☐	☐	☐			
16. Refuse to share.	☐	☐	☐			
17. Take things that do not belong to him/her.	☐	☐	☐			
TOTAL:						

Client Name

Client ID

Caregiver/Guardian/Parent

Client DOB:

Date

MultiCare Behavioral Health
BetterConnected

GAIN – Nicotine Use and Dependency Screening Tool

1. When was the **LAST** time you smoked or used any kind of tobacco? Please include cigarette, cigars, chewing tobacco, pipes and e-cigarettes. **(CIRCLE ONE)**

Within the past two days	6
3 to 7 days ago	5
1 to 4 weeks ago	4
1 to 3 months ago	3
4 to 12 months ago	2 (Go to #4)
More than 12 months ago	1 (Go to #4)
Never	0 (Stop)

Please answer the next questions using number of days or times

2. **During the past 90 days,** on how many **days** have you smoked or used **any** tobacco? _____

3. On those days, **how many times per day** did you usually smoke or use any kind of tobacco? (Note: A pack of cigarettes would be about 20 times). _____

4. How old were you when you first smoked or used any kind of tobacco? _____

Next we want to go over a list of common problems related to tobacco use. After each of the next questions, we would like you to tell us the last time you had this problem	Past Month	2-12 Months	1+ Years	Never
5. When was the **last** time that…				
a. You needed more tobacco to get the same effect?	3	2	1	0
b. You had headaches or other withdrawal symptoms when you tried to stop or cut down on your tobacco use?	3	2	1	0
c. You used more tobacco or used it longer than you meant to?	3	2	1	0
d. You were unable to cut down or stop using tobacco?	3	2	1	0
e. You spent a lot time using or getting tobacco?	3	2	1	0
f. Tobacco caused you to give up activities or caused problems?	3	2	1	0
g. You kept using tobacco despite medical or psychological problems?	3	2	1	0

How to interpret nicotine dependency scores: **TOTAL SCORE:** _____

A score of 3 or higher in a 5 a-g indicates nicotine dependence per DSM IV-TR criteria: Continue with supplemental question below. If 5a or 5b is endorsed, a modifier of physiological dependence may be added.

Supplemental question: time to first cigarette (TTFC): How soon after waking up do you use tobacco?

_____Within 5 minutes _____6-30 minutes _____ 31-60 minutes _____ After 60 minutes

≤30 minutes = moderate dependence: ≤5 minutes = severe dependence: Nicotine replacement therapy should be recommended.

This form was created from Section R in the GAIN-I assessment with permission from Chestnut Health System.

Client Name: First MI Last	Client ID #:
GAIN – Nicotine Use & Dependency Screen	**Date:**

Gambling is the activity or practice of playing at a game of chance for money or other stakes.

This can include activities for money such as: cards, betting on animals or sports, dice games, casino games, lotteries, bingo, slot machines, or games of skill (i.e., bowling, pool, golf)

Please circle the response that best fits you for each of the following questions.

1. In the past 12 months have you gambled more than you intended to?	No	Yes	N/A
2. In the past 12 months have you claimed to be winning money when you were not?	No	Yes	N/A
3. In the past 12 months have people criticized your gambling?	No	Yes	N/A
4. In the past 12 months have you had money arguments centered on gambling?	No	Yes	N/A
5. In the past 12 months did you feel you had to persist until you won?	No	Yes	N/A
6. If you answered yes to 2 or more of these questions, how often has it happened?	Once	Only Sometimes	Often

Questions 1-6: # of Yes = _____

Client Name:	First MI Last	Client ID #	
CAMH Gambling Screen		**Date:**	

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

WHO WILL FOLLOW THIS NOTICE

This Notice describes the practices of MultiCare Health System ("MultiCare") and that of:

- Any health care professional authorized to enter information into your chart at any MultiCare facility.
- All departments and units of MultiCare.
- Any member of a volunteer group we allow to help you while you are at a MultiCare facility.
- All MultiCare employees and personnel including contracted or agency staff.
- Other health care providers who have agreed to follow and abide by the "joint notice of privacy practices" terms described below.

JOINT NOTICE OF PRIVACY PRACTICES

In addition to those persons identified above, a number of other independent practitioners have agreed with MultiCare to follow this Notice as a joint privacy practices notice in accordance with federal privacy laws related to care delivered at MultiCare facilities, including the members of the medical staffs of Tacoma General Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Good Samaritan Outreach Services, Auburn Medical Center and other independent providers or organizations delivering care at MultiCare facilities. The independent practitioners that have agreed to follow this Notice may access your health information where there is a legitimate need to do so for treatment, payment and health care operations purposes related to the joint care setting at MultiCare facilities. The independent practitioners that have agreed to follow this joint notice likely will have separate Notice of Privacy Practices for care delivered at non-MultiCare facilities (e.g. a physician's office). You are encouraged to request information from a non-MultiCare practitioner about any separate Notice of Privacy Practices followed by that practitioner at non-MultiCare offices or facilities.

Community Provider Access to Your Electronic Health Record To improve care, quality outcomes and access to your health records by providers in the community, MultiCare Health System provides connectivity to its Electronic Health Record system to independent community health care providers and members of the medical staffs of MultiCare's affiliated hospitals ("Connected Providers"). As a condition of such access, Connected Providers each agree to abide by appropriate privacy and security measures, including compliance with federal and state laws regarding the privacy and security of your health information. Connected Providers with a "need to know" typically have full access to your electronic health record. For any questions concerning MultiCare's role in providing electronic records access to Connected Providers, please call our Privacy Office at 253.459.8300. MultiCare also provides you with limited access to your electronic health record under MultiCare's MyChart programs. For information on MyChart, see www.multicare.org.

MULTICARE CONNECTED CARE NETWORK

We are part of the MultiCare Connected Care Network which is an organized healthcare arrangement (OHCA). An OHCA is (i) a clinically integrated setting in which individuals typically receive healthcare from more than one healthcare provider or (ii) an organized system of healthcare in which more than one health care provider participates. The healthcare providers who participate in the OHCA will share medical and billing information about you with one another as may be necessary to carry out treatment, payment, and healthcare operations activities.

MULTICARE'S PLEDGE AND RESPONSIBILITIES REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting health information about you and are required under federal and state law to take steps to protect this information. Under federal privacy laws, this information is called "protected health information." Protected health information includes certain information we have created or received that identifies you, including information regarding your health or payment for your health at a MultiCare facility, whether by hospital personnel, your personal doctor or other practitioners involved in your care. It includes your medical records and personal information such as your name, social security number, address, and phone number.

MultiCare is required by law to:

- Take steps to protect the privacy of the medical information that identifies you;
- Provide you this Notice of our legal duties and privacy practices with respect to medical information about you;
- Notify you following a compromise of unsecured protected health information; and
- Follow the terms of the Notice that is currently in effect.

USES AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION BY MULTICARE

MultiCare uses and discloses your protected health information in many ways related to your treatment, payment for your care, and our health care operations. Some examples of how we may use or disclose your protected health information are listed below.

Your authorization is required in the following circumstances:

- The use and disclosure of psychotherapy notes;
- Disclosures that constitute a sale of protected health information;
- The use and disclosure of your protected health information for marketing purposes where we receive financial remuneration; and
- For any other uses and disclosures not described in this Notice of Privacy Practices.

We may use or disclose your protected health care information to provide you with medical treatment or services without a signed consent for continuity of care:

- To doctors, nurses, technicians, health care students, or other health system personnel who are involved in your care.
- To different departments to coordinate activities such as prescriptions, lab work and x-rays.
- To other health care providers who may be involved in your medical care, such as long-term care facilities, other hospitals or clinics, or remote health care providers such as the services offered by telemedicine providers who may reside in other communities, including communities outside of Washington.

Federal and state laws may place additional limitations on the use of your protected health information for drug or alcohol abuse, sexually-transmitted diseases, or mental health treatment.

As permitted by law, we may use or disclose your protected health information in relation to payment for health services you receive.

- To bill for treatment and services you receive at a MultiCare facility.
- To collect payment for treatment and services you receive at a MultiCare facility.
- To obtain prior approval for treatment and services from your insurance plan.

We may use or disclose your protected health information in relation to health system operations.

- To administer or support our business activities or those of other health care organizations (as allowed by law) including providers and insurance plans.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your protected health information with other organizations for this purpose, they also must agree to protect your privacy).

These uses and disclosures are necessary to operate the health system and ensure patients receive quality care. Examples could include review of treatment to evaluate staff or identify training needs, to review outcomes of care, or to send you a patient satisfaction survey.

We may also use or disclose your protected health information in the following miscellaneous circumstances.

Contacting You – We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone, or email. For example, we may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

Treatment Alternatives – To tell you about or recommend possible treatment options or alternatives.

Health-Related Benefits and Services – To tell you about health-related benefits, services, or medical education classes.

Business Associates – We may disclose your health information to other entities that provide a service to us or on our behalf that requires the release of your health information, such as billing service, but only if we have received satisfactory assurance that the other entity will protect your health information.

Organized Health Care Arrangements (OHCA) – An organized healthcare arrangement is characterized by separate healthcare providers that participate in joint activities to share protected health information about their patients in order to deliver healthcare together and improve hospital operations. These are common hospital settings, but are expanding to include a wide range of ambulatory outpatient care across all health care service lines.

Fundraising Activities – Limited information about you (name, address, phone number, email, age, date of birth, gender, health insurance status, treating physician, dates, and departments of service at MultiCare) may be used and disclosed to support MultiCare's fundraising activities. If you no longer wish to receive fundraising requests supporting MultiCare, please call (toll-free) 855.884.4284, or alternatively send an e-mail to annualgiving@multicare.org. We respect your choice regarding fundraising communications and your decision will have no impact on your treatment or payment for services at MultiCare.

Marketing Materials – Limited information about you may be used to support communication about available products or services. If you do not wish to receive such materials, please call 253.403.1261.

Health Information Exchanges - We may participate in health information exchange networks to facilitate the secure exchange of your electronic health information regarding your treatment between and among other health care providers or health care entities including but not limited to Emergency Department Information Exchange (EDIE), Virtual Lifetime Electronic Record (VLER - DoD/VA), or CareEverywhere (Organizations with Epic).

Research – For research purposes, under certain circumstances. All research projects, however, are subject to a special approval process. Unless specially approved, we will ask for your specific permission to determine if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at the health system.

Telemedicine – Modern technologies are enabling new methods of delivering health care in circumstances where the patient is in one location and the health care provider is at another location. Telemedicine providers may be consulted by your physicians or other care team members, and at times you may interact directly with a telemedicine provider using technologies to allow direct communication. In most circumstances, your telemedicine provider will have direct access to your medical records in the same manner, and often to the same extent, that your local "in person" health care providers have.

As Required By Law – When required to do so by federal, state or local law.

We may also use or disclose your protected health information in the following special situations:

Organ and Tissue Donation – If you are an organ donor, to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transportation.

Blood Conservation Services – If you have indicated affiliations with certain organizations and we believe you may be an ideal candidate who could benefit from blood conservation services.

Military – As required by law, if you are a member of the armed forces.

Workers' Compensation – As properly requested by workers' compensation or similar programs, including providing a report of accident with the state Labor & Industries Department or another's worker's compensation program.

Public Health and Safety – To agencies when necessary, to prevent a serious threat to your health and safety or the health and safety of the public or another person.

These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

Health Oversight Activities – To a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes – In response to a court or administrative order, subpoena, discovery request, or other lawful process, if you are involved in a lawsuit or a dispute.

Law Enforcement – To law enforcement officials in limited circumstances for law enforcement purposes such as locating a suspect, fugitive, material witness, or missing person; reporting a crime; or providing information about a victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement.

Coroners, Medical Examiners, and Funeral Directors – To coroners, medical examiners, or funeral directors as required by law and necessary to perform their duties.

Military Activity and National Security – To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law or in connection with providing protection to the United States President, other authorized personnel or foreign heads of state or conducting special investigations.

Correctional Facilities – To a correctional facility or law enforcement official, if you are an inmate or under custody.

USE AND DISCLOSURE WHEN YOU HAVE THE OPPORTUNITY TO OBJECT

Patient Directory – We will include limited information about you in the patient directory while you are a patient at a MultiCare hospital. This information may include your name, location in the hospital and your general condition (e.g. fair, stable, etc.) and, with your permission, your religious affiliation. The directory information, except your religious affiliation, may be released to people who ask for your by name unless you have instructed us not to do so. Also, with your permission, we may tell members of the clergy your religious affiliation. This information helps your family and friends visit you in the facility and know your general health condition.

Individuals Involved in Your Care – Unless you object, your healthcare provider will use his or her professional judgment to provide relevant protected health information to your family, friends, or another person. This person would be someone you indicate has an active interest in your care or the payment for your healthcare or who may need to notify others about your location, general condition or death.

Disaster Relief – We may disclose to an organization assisting in a disaster relief effort so that your family and friends can be notified about your general health condition and location.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We may also share your information when needed to lessen a serious and imminent threat to health or safety.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by our current Notice or applicable laws will only be made with your written permission.

You may revoke any permission by submitting a request in writing to the MultiCare Privacy Office (at the contact information under Questions & Complaints). If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written authorization unless required by law. You understand that we are unable to take back any uses or disclosures we have already made, while your permission was in effect, and that we are required to retain our records of the care that we provide to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Unless indicated otherwise, you may exercise one of your privacy rights by submitting a written request to the MultiCare Health System, Health Information Management, PO Box 5299, MS: 315-C3-HIM, Tacoma, WA 98415-0299. For more specific instructions on what information to include in a written request, contact Health Information Management by phone 253.403.2433.

YOU HAVE A RIGHT TO:

Request to inspect and/or copy your protected health information that may be used to make decisions about your care – Usually this includes medical and billing records and does not include psychotherapy notes. To request an opportunity to inspect and/or copy your protected health information in either paper or electronic format, visit www.multicare.org to obtain a copy of the authorization request form or contact Health Information Management (medical records) at 253.403.2433 for inpatient records and 253.372.7175 for any MultiCare Clinic outpatient records. You may be charged a fee for copying, mailing or other supplies associated with your request. In certain limited circumstances, we may deny your request to inspect and/or copy your protected health information. You may request that the denial be reviewed.

Ask us to amend certain protected health information – If you feel that information we have about you is incorrect or incomplete you can request an amendment to such information.

Request an accounting of certain disclosures – You may request an accounting of certain disclosures of protected health information we have about you listing all the disclosures we made of your protected health information to others except for the purposes of treatment, payment, and health care operations identified previously. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Request restrictions – You may request in writing that we limit the way we use and disclose your protected health information. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. If you want to put such a restriction in place, please notify your healthcare providers.

We are not legally required to agree to all restriction requests. If we do agree to your request, we will comply unless the information is needed to provide emergency treatment.

Right to request nondisclosure to health plans for self-paid items or services – You have a right to request in writing that healthcare items or services for which you self-pay for in full in advance of your visit not be disclosed to your health plan (except as otherwise required by law). You are responsible for notifying any other providers, such as your pharmacy, of any restriction requests.

Request confidential communications – You may request in writing that confidential communications about medical matters be made 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 an alternative address. We will accommodate all reasonable requests. You do not have to provide a reason, but the request must specify how or where you wish to be contacted.

Choose someone to act for you – If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Receive a paper copy of this notice – You can request a copy of this Notice at any time from any MultiCare employee.

CHANGES TO THIS NOTICE

MultiCare reserves the right to change this Notice. A current copy of the Notice, including the effective date, will be posted on our website at www.multicare.org and paper copies will be available at our facilities.

QUESTIONS AND COMPLAINTS

If you have general questions about this Notice, please contact the MultiCare Privacy Office by phone: 253.459.8300 or email: compliance@multicare.org. If you believe your privacy rights have been violated, you may file a written complaint with the MultiCare Privacy Office, MultiCare, P.O. Box 5299, MS: 737-2-CCIA, Tacoma, WA 98415-0299. If we cannot resolve your concerns, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services (HHS), Office for Civil Rights, 220 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.