Application Packet

Welcome!

Thank you for your interest in Rainforest Recovery Center. It takes courage to reach out for help, and we applaud your willingness to do so. Recovery isn’t easy, but treatment can help get you on the road to recovery. The process begins with completing this inquiry form. We’ll ask some basic information and get a general idea of what you want.

How to Apply:

Below is information needed to apply for services. Appointments for screening and assessment can be made in person or by phone at 907-796-8690. Completion and submission of the Patient Demographics form as well as the Billing Information before your appointment can save time but can be filled out when you arrive as well.

If you are seeking residential treatment services, the medical section of this Application Packet also needs to be completed and submitted. All your information will then be reviewed by our treatment team.

Once the Application Packet has been completed and the screening and assessment conducted, the treatment team will make a decision about the most appropriate level of care and notify you.

Application Checklist:

☐ Authorization for Releases of Information (see below)
☐ Patient Demographics form (see below)
☐ Billing Information form (see below)
☐ Copy of Substance Use or Behavioral Health Assessment if done within the last 6 months

If you are applying for Residential Treatment you will also need to submit:

☐ Medical History & Physical completed within the last 30 days by your MD, DO, Nurse Practitioner, or Physician Assistant.
☐ TB test completed within the last year
☐ List of current medications

Application Packet forms and records can be sent to Rainforest Recovery Center by any of the following methods:

Fax: 907-586-5605

Mail or In Person: Rainforest Recovery Center, Medical Records
3250 Hospital Drive
Juneau, AK 99801

We look forward to serving you!
AUTHORIZATION FOR RELEASE OF INFORMATION

Rainforest Recovery Center is a part of Bartlett Regional Hospital and as a hospital system we provide integrated care. By signing this Release of Information you are allowing for consultation with hospital physicians and other hospital staff to allow you to receive the best medical care possible. We ask this release be completed prior to treatment admission so there is no delay in services.

**PATIENT INFORMATION**

| Patient Name: ________________________________________ | Birth Date: ______________ | Medical Record # (if known): ____________ |
| Address: __________________________________________ | City / State / Zip: ____________________________ |

I hereby Authorize Rainforest Recovery Center to Release Information TO:

Name of Facility/ Organization / Individual: Bartlett Regional Hospital

Address: 3260 Hospital Drive

City / State / Zip: Juneau, AK 99801  Phone Number: 907-796-8900

I hereby Authorize Rainforest Recovery Center to REQUEST Information FROM:

Name of Facility/ Organization / Individual: Bartlett Regional Hospital

Address: 3260 Hospital Drive

City / State / Zip: Juneau, AK 99801  Phone Number: 907-796-8900

☐ Purpose or need for information being requested: Further Treatment.
☒ Type of Information to be used or disclosed: Entire Record.

I authorize the release of information relating to: Substance Use Disorder Information and Psychiatric Evaluation / Treatment.

This information may be transmitted via Fax, Verbal, Electronically, and Hard Copy.

This Authorization expires 7 years from signing to enable ongoing coordination of care.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at RRC. I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.

The following Prohibition on Re-disclosure will accompany all information released pursuant to this release: “The confidentiality of the records from which this information has been disclosed is protected under Federal law. Federal regulations (42 CFR, Part 2) prohibits recipients of the information from making any further disclosure without the specific written consent of the person to whom it pertains or other permitted by the regulations. I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, RRC their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

I understand that my alcohol and / or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records 42 CFR, Part 2 and 45 CFR, and HIPAA and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent through verbal communication or in writing at any time, except to the extent that action has been take in reliance on it. Submit written revocation to the RRC HIM Department.

I further acknowledge that the information to be released has been explained to me and certify that this consent is being given of my own free will.

**PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

<table>
<thead>
<tr>
<th>Signature of Patient or Legally Responsible Party</th>
<th>Relationship to Patient</th>
<th>Date</th>
</tr>
</thead>
</table>
Patient Demographics

Identifying Data
Full Legal Name: ___________________________ SSN: ___________________________ DOB: ___________ Age: ___________
Preferred Name: ___________________________ Sex: □ M □ F Identify as: □ M □ F □ Other
Maiden Name: ___________________________

Contact Information – Current
Physical Address: ___________________________ Home Phone: ___________________________
Mailing Address: ___________________________ Cell Phone: ___________________________
City & State: ___________________________ Work Phone: ___________________________
Employer: ___________________________

May we leave a message identifying RRC on your phone? □ Yes □ No

If Applicable: □ Guardian □ Payee
Name: ___________________________ Home Phone: ___________________________
Physical Address: ___________________________ Cell Phone: ___________________________
Mailing Address: ___________________________ Work Phone: ___________________________
City & State: ___________________________
Employer: ___________________________

Emergency Contact Numbers:

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Relationship to Client</th>
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Why are you seeking services at this time? __________________________________________________________ ________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Are you currently? □ Pregnant
- If pregnant what is the due date? __/__/__

What is your drug of choice? ____________________________________________________________

What is your goal for treatment? __________________________________________________________

What date are you available to start treatment? ________________

Signature: __________________________________Date: ___________________________
Billing Information / Authorization

Expected Payment Source (check all that apply):

- Medicaid (Includes Denali Kid Care)  - Other Insurance  - Self-pay

Rainforest Recovery Center offers Charity Care Programs for qualifying applicants. If you are self-paying and do not have insurance, please apply for our Sliding Fee Scale application. You may ask our front office for more information or contact Patient Financial Services at 907-796-8328.

Medicaid ID Number:
Please provide a copy of proof of coverage from Medicaid.

Insurance (All asterisked information must be completed.)
Copy of both sides of insurance card. Enlarge copy so it is legible when faxed.

<table>
<thead>
<tr>
<th>*Name of Primary Insurance Company</th>
<th>Subscriber’s Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Subscriber’s (Policy Holder) Name</td>
<td>Insurance Company Address</td>
</tr>
<tr>
<td>*Subscriber’s ID Number</td>
<td>Insurance Company Phone</td>
</tr>
<tr>
<td>*Subscriber’s Date of Birth</td>
<td>Group or Plan #</td>
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<tr>
<td>Relationship to Patient</td>
<td>Subscriber’s Address (if different from above)</td>
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<tr>
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<td>Subscriber’s Home Phone (if different)</td>
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Your insurance will be billed separately for physician services. You may receive a bill from Southeast Physician Services for any balance not covered by insurance.

Signature: ____________________________ Date: _________________________
Informed Consent for Treatment

**Confidentiality** Your attendance and all communications between you and your treatment staff, including psychiatrists, are confidential and are not released without your signed consent. Authorization-to-release information forms are available for this purpose. Your RRC records are kept separate from your BRH medical records. The records will be maintained for at least seven years from the last day of service. Rainforest Recovery Center is a part of Bartlett Regional Hospital and as a hospital system we provide integrated care.

**Limits to Confidentiality:**
1. When there is a clear and present danger of harm to either yourself or others, we may act on your behalf by arranging hospitalization or notifying others.
2. If you disclose actual or possible current child abuse or neglect, or the abuse, neglect or exploitation of a disabled adult in need of protection, we must report the information to the appropriate department of social services.
3. If we are ordered by a court of law to release information about you, we must do so.
4. In social situations, such as activities off campus, your involvement in Rainforest Recovery Center may be incidentally disclosed.
5. In the event you may need emergency medical care and are brought to BRH you are covered under 42CFR Part 2.
6. Separate Release of Information forms need to be signed for each outside agency you visit while at RRC.

The following Prohibition on Re-disclosure will accompany all information released pursuant to this release: “The confidentiality of the records from which this information has been disclosed is protected under Federal law. Federal regulations (42 CFR, Part 2) prohibits recipients of the information from making any further disclosure without the specific written consent of the person to whom it pertains or other permitted by the regulations. I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, RRC their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

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I have read the above statements. I understand my rights and responsibilities of confidentiality, as well as Rainforest Recovery Center’s confidentiality limitations. I agree it is for my benefit during treatment to abide by the appropriate confidentiality agreement listed above to protect my health and safety.

__________________________  __________________________
Signature  Date/Time

Witness