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.	Threatened, hit, or hurt badly within the family.	☐ Yes ☐ No
4.	Threatened, hit, or hurt badly in the school or the community.	☐ Yes ☐ No
5.	Attacked, stabbed, shot at, or robbed by threat.	☐ Yes ☐ No
6.	Seeing someone in the family threatened, hit, or hurt badly.	☐ Yes ☐ No
7.	Seeing someone at school or the community threatened, hit, or hurt badly.	☐ Yes ☐ No
8.	Someone doing sexual things to you or making you do sexual things to them when you couldn't say no. Or when you were forced or pressured.	☐ Yes ☐ No
9.	Online or in social media, someone asking or pressuring you to do something sexual. Like take or send pictures.	☐ Yes ☐ No
10.	Someone bullying you in person. Saying very mean things that scare you.	☐ Yes ☐ No
11.	Someone bullying you online. Saying very mean things that scare you.	☐ Yes ☐ No
12.	Someone close to you dying suddenly or violently.	☐ Yes ☐ No
13.	Stressful or scary medical procedure.	☐ Yes ☐ No
14.	Being around war.	☐ Yes ☐ No
15.	Other stressful or scary event? Describe: _____	☐ Yes ☐ No

**** 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**

CLIENT NAME (PRINTED): _____

MRN: _____ DATE: _____

Child and Adolescent Trauma Screen (CATS) – Youth Report

Revised 11/30/2022

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please CIRCLE your answer)*	**Not at all**	**Several days**	**More then 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—or 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 of hurting yourself in some way	0	1	2	3
Add columns:		+	+	+

TOTAL: (*Healthcare professional: for interpretation of TOTAL, please refer to accompanying scoring card)*	

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

CLIENT NAME (PRINTED): _____

MRN: _____ DATE: _____

PHQ-9

Revised 11/30/2022

Generalized Anxiety Disorder Scale (GAD7)

Over the last two weeks, how often have you been bothered by any of the following problems? *(Circle or use an "X" to indicate your answer)*				
	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)*				

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

CLIENT NAME (PRINTED): _____

MRN: _____ **DATE:** _____

GAD 7

Revised 11/30/2022

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
(PRINTED): _____

MRN: _____ **DATE: _____**

GAIN-SS

Revised 11/30/2022

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Washington State Health Care Authority

Behavioral health treatment options for adolescents

PATIENT'S NAME MEDICAL RECORD NUMBER

Parents or guardians seeking a mental health or substance use evaluation or treatment for an adolescent age 13 to 17 years old must be notified of all legally available treatment options. These include Adolescent-Initiated Treatment (formerly minor-initiated treatment), Family-Initiated Treatment (formerly parent-initiated treatment), and Involuntary Commitment. Beginning July 2019, HB 1874 expands adolescent behavioral health (BH) treatment access, by broadening Family-Initiated Treatment (FIT) language under RCW 71.34 to include outpatient treatment services and guidelines regarding information that can be disclosed to a parent, guardian, or behavioral health provider without consent of the adolescent.

Adolescent-Initiated Treatment (RCW 71.34.500-530)

An adolescent, 13 to 17 years old, may request an evaluation for outpatient or inpatient mental health or substance use disorder treatment without parental consent. If the facility agrees with the need for outpatient mental health or substance use disorder treatment, the adolescent may be offered services. An inpatient admission shall occur only if the professional person in charge of the facility concurs with the need for inpatient treatment. For a minor under the age of 13, either parental consent or consent from an approved guardian is required for inpatient treatment.

Family-Initiated Treatment (RCW 71.34.600-670)

The parent, guardian, stepparent, kinship caregiver, other relative or authorized individual may bring their adolescent age 13 to 17 years old to any mental health evaluation and treatment facility, hospital, inpatient facility or an approved substance use disorder (SUD) treatment program and request that a mental health evaluation or substance use disorder assessment be conducted by a professional person to determine whether the adolescent has a mental health or substance use disorder and is in need of inpatient or outpatient treatment. The evaluation in an inpatient setting cannot take longer than 72 hours. Consent of the adolescent is not required for either an outpatient or inpatient mental health or substance use disorder evaluation. *Please see new definition of parent **RCW 71.34.020(25)(a)**.*

Please note: *No provider is obligated to provide treatment to an adolescent under the provisions of FIT. However, an adolescent's refusal to consent to treatment shall not be the sole basis for a facility's decision to decline services.*

Family-Initiated Outpatient and Intensive Outpatient Treatment

If it is determined by the professional person that the adolescent age 13 to 17 years old has a mental health or substance use disorder, and is in need of *outpatient treatment*, services can be offered to the adolescent through FIT. FIT specifies that a parent may access and consent for up to 12 outpatient mental health and/or SUD sessions for an adolescent with a specific professional person within a 3 month period. The outpatient professional delivering services must notify the Health Care Authority's (HCA) contracted reviewer that an adolescent has begun receiving outpatient treatment within the first 24 hours of the initial services under Family-Initiated Treatment, and again every 45 days throughout the 3 month period. Following the treatment period, an adolescent must provide consent for further treatment with the same outpatient provider.

Family-Initiated Inpatient Treatment

If it is determined by the professional person that the adolescent age 13-17 years old has a mental health or substance use disorder and there is medical need for inpatient treatment, the parent or guardian may request that the adolescent be held for treatment. If the inpatient program believes the adolescent needs to be held for treatment, the inpatient facility must notify HCA's contracted reviewer that an adolescent has been admitted for

treatment under Family-Initiated Treatment within 24 hours of the completion of the evaluation. If the inpatient program believes the adolescent must be held for more than 7 days, the inpatient program must notify HCA that a review for the continued need of inpatient treatment needs to be completed. The adolescent must be notified by the facility of his or her right to petition the Superior Court for release from the facility not sooner than five days after the review. Any adolescent receiving treatment under this chapter must be released from the inpatient facility within 30 days of the HCA contracted reviewer's review unless the adolescent is admitted under voluntary status or the professional person or Designated Crisis Responder (DCR) initiates involuntary commitment proceedings under this section.

If HCA's contracted reviewer's review determines that the adolescent no longer meets medical criteria for inpatient treatment, the parent or guardian must be immediately notified and the adolescent must be released within 24 hours. In this case, if the parent or guardian and facility both believe it is medically necessary for the adolescent to remain in inpatient treatment, the facility will hold the adolescent until the second judicial day following the HCA review. This will allow the parent or guardian time to file an at-risk youth petition pursuant to **RCW 13.32A.191**. Family Reconciliation Services (**RCW 13.32A.040**) may also be provided through the Department of Children, Youth, and Families (DCYF).

Adolescents admitted to an inpatient facility under Family Initiated Treatment must be released from the facility immediately upon the written request of the parent.

Involuntary Treatment (RCW 71.34.700-795)

If an adolescent 13 years or older presents a likelihood of serious harm to themselves or others, who is gravely disabled and may be in need of immediate mental health or substance use inpatient treatment and refuses to consent to a voluntary admission, the adolescent may be held for up to 12 hours to enable a DCR to evaluate the adolescent for possible involuntary commitment. If no voluntary or less restrictive treatment alternatives are available, and the DCR determines that the adolescent presents a likelihood of serious harm or is gravely disabled, as a result of a mental health or substance use disorder, the adolescent may be held at a facility. An adolescent may only be subject to involuntary commitment for substance use disorder treatment if a secure withdrawal management and stabilization facility or approved substance use disorder treatment program is available and has adequate space for the adolescent.

If the adolescent is already admitted to an inpatient mental health or substance use treatment facility, they may be seen by a mental health or substance use disorder professional and the staff within 24 hours to determine whether to pursue involuntary commitment court proceedings. Under involuntary treatment act, the adolescent can initially be held for treatment up to 72 hours, excluding weekends and holidays. During this time, the facility may petition the court to have the adolescent committed for an additional 14 days, if it is believed further treatment is necessary. At the end of the 14 days, the facility may file a petition for up to 180 days of additional inpatient treatment.

If the DCR does not hold the adolescent, the parent or guardian may seek review of the decision, pursuant to 71.05.201, by filing notice with the court and providing a copy of the DCR's report and/or notes.

If the adolescent is released from hospitalization on a conditional release or a less restrictive alternative court order, and is not following the conditions of that release or court order, or has substantially deteriorated in their functioning, the adolescent can be evaluated and taken into custody by a DCR and transported to an inpatient evaluation and treatment facility for mental health treatment or to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, if a facility is available and has adequate space for the adolescent for substance use disorder treatment. For further assistance or questions, call your local behavioral health crisis line.

Providers' Mandatory Review Notifications

Within 24 hours of FIT admission the provider must notify the HCA contracted reviewer, The FIT Administration Office, via secure email at fitreporting@fitadministration.com or via secure fax at 206-859-6432

The notification shall include:

- Name and Date of Birth
- Date of FIT admission or status change to FIT
- County in which the adolescent lives, and
- Insurance type

Between 7 – 14 days of an adolescent's admission, and every 45 days that treatment in outpatient or intensive outpatient continues, the provider must send the following information to HCA's contractor for review of medical necessity:

- Admittance face sheet
- Intake assessment note
- Discharge summary

☐ I have been provided with written and verbal notice of the available treatment options for the adolescent.

Parent/guardian's signature **Date** **Facility representative's signature** **Date**

_____ _____ _____ _____

☐ **Unable to obtain parent/guardian signature or acknowledgement.**

Reason for lack of signature:

Facility representative's signature **Date**

_____ _____

For more information about Family Initiated Treatment, please contact:

HCAFamilyInitiatedTreatment@hca.wa.gov

Updates

March 17, 2020:

- Changed contact for admissions and reviews to:
  FIT Administration Office, via secure email at fitreporting@fitadministration.com or via secure fax at 206-859-6432.

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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.	Threatened, hit, or hurt badly within the family.	☐ Yes ☐ No
4.	Threatened, hit, or hurt badly in the school or the community.	☐ Yes ☐ No
5.	Attacked, stabbed, shot at, or robbed by threat.	☐ Yes ☐ No
6.	Seeing someone in the family threatened, hit, or hurt badly.	☐ Yes ☐ No
7.	Seeing someone at school or the community threatened, hit, or hurt badly	☐ Yes ☐ No
8.	Someone doing sexual things to the child or making the child do sexual things to them when he/she couldn't say no. Or when the child was forced or pressured.	☐ Yes ☐ No
9.	Online or in social media, someone asking or pressuring the child to do something sexual. Like take or send pictures.	☐ Yes ☐ No
10.	Someone bullying the child in person. Saying very mean things that scare him/her.	☐ Yes ☐ No
11.	Someone bullying the child online. Saying very mean things that scare him/her.	☐ Yes ☐ No
12.	Someone close to the child dying suddenly or violently.	☐ Yes ☐ No
13.	Stressful or scary medical procedure.	☐ Yes ☐ No
14.	Being around war.	☐ Yes ☐ No
15.	Other stressful or scary event? Describe: _____	☐ Yes ☐ No

**** 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**				

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)

Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

CLIENT NAME **(PRINTED): _____** **MRN: _____ DATE: _____**	**Pediatric Symptom Checklist-17 (PSC-17)** **Revised 11/30/2022**

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MultiCare
Behavioral Health Network

Acknowledgment of Conditions for Treatment & Financial Disclosures - Outpatient

I agree and consent to receive outpatient mental health and/or substance use disorder (SUD) treatment and services from (*select only one provider*):

- [X] MultiCare Behavioral Health – Mental Health
- [ ] MultiCare Behavioral Health – SUD
- [ ] Navos – Mental Health
- [ ] Navos – SUD
- [ ] Greater Lakes – Mental Health
- [ ] Greater Lakes – SUD

CONSENT FOR CARE: I agree to care and treatment by MultiCare Health System ("MultiCare") together with other health care professionals employed by or otherwise affiliated with MultiCare (i.e. Navos, MBH, Greater Lakes, Behavioral Health Network (BHN)) who are designated to provide care for me. This consent may include examinations, assessments, tests, labs, mental health or substance use disorder treatment. I understand that I have the right to ask questions about my care at any time, and to be involved in my care decisions.

NO GUARANTEE OF RESULTS OR CURE: No promise or guarantee of results or cure has been made to me.

PHOTOGRAPHS FOR TREATMENT, DIAGNOSIS AND/OR IDENTIFICATION: For diagnosis and treatment purposes, I allow images such as photographs to be taken and used. This includes video and electronic monitoring or recording methods. These images may be used to add to written information about my illness or injury. Some images are used once and immediately discarded when no longer needed. Others may be kept as part of my medical record, at the option of my treatment providers. Photographs of me may also be taken for identification purposes.

IMAGES OR RECORDINGS OF HEALTH CARE PROVIDERS AND FACILITIES: I understand I must obtain the permission of all health care provider(s) and any other individuals present before I can take photographs or video of any members of my care team. I also understand I cannot record conversations by any means without first obtaining the permission of all persons being recorded.

I am aware that my provider uses video surveillance in lobbies and in external locations (such as parking lots) for security and operational purposes.

FINANCIAL AGREEMENT: I agree to pay MultiCare affiliates (Navos, Greater Lakes, MBH) for care at its regular rates and terms applicable to my care and any applicable health insurance coverage I have. I permit MultiCare 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, subject to any applicable contractual or governmental regulations. If a third party caused my injuries, I understand that MultiCare may file a medical services lien as permitted under RCW 60.44.010. (This lien attaches only to a portion of the proceeds of any settlement between me and the party that caused me harm.) If my bill is sent to a lawyer or collection agency, I will pay all reasonable attorneys' fees and costs, together with interest and any amounts otherwise found to be owing. Information about the estimated charges for health services is available upon request. I understand I have the right to request this information.

I understand that my provider may send my identifying information to third party payers such as Managed Care Organizations, Medicare, Medicaid, etc. All client information sent pursuant to these types of agencies is confidential and used solely for billing purposes. I consent to and specifically authorize the disclosure of my mental health and/or substance use disorder information to these agencies.

AGENTS & CONTRACTORS: Whenever MultiCare is referenced above, it is my intent to include its employees, officers, agents, attorneys, first and third-party liability and claims agents, third-party claims administrators and collection agencies, as well as their agents or employees, to receive any information that MultiCare would otherwise be entitled to receive.

MEDICARE: If I am a Medicare participant, I understand that I need to pay for services that are not covered by the Medicare Program. This may include, but is not limited to services covered by car or liability insurance, or where a third party is otherwise responsible for any accident or injury leading to my need for care, as well as any services not otherwise covered by Medicare.

CO-INSURANCE: There may be a co-insurance for care given related to my Medicare or other insurance benefits.

PHONE, EMAIL, TEXT MESSAGING AUTHORIZATIONS: I grant permission and consent to MultiCare and their affiliates: (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, unless I have exercised an "opt out" option associated with such emails or text messages or have otherwise notified MultiCare in writing to discontinue such communications using those pathways. (I understand that opt out processes may take up to ten (10) business days to go into effect.) I understand that I am not required to accept messages in these formats as a condition of receiving services at MultiCare or their affiliates.

EMAIL CONTAINING PROTECTED HEALTH INFORMATION; MYCHART: I understand that exchanging email, text or other written communications with my health care provider(s) or other members of my care team can result in protected health information being disclosed to unauthorized persons, and that MultiCare cannot control who views such information when sent in unencrypted form. I understand that MultiCare offers "MyChart" to all patients, which provides a fully encrypted and protected pathway for communicating with most of its providers, although not all MultiCare providers choose to utilize MyChart. If I initiate or respond to communications using unencrypted pathways, I assume the risk that my information may be compromised, and I authorize MultiCare and its providers to communicate with me using that process, unless or until I choose to opt out of such communications pathways by notifying my provider in writing, allowing up to ten business days to implement any change in my communications pathways.

ADVANCE DIRECTIVES / LIVING WILL: I understand that I have the right to carry out an Advance Directive for Health Care (Often referenced as a "Living Will.") and/or Advance Directive for Mental Health. I understand that I can get information on the Advance Directive policy from my provider. If I have completed an Advance Directive form, I agree to provide a copy of such form(s) to my provider.

HEALTH CARE POWER OF ATTORNEY / MENTAL HEALTH POWER OF ATTORNEY: I understand I can nominate another person or persons to make health care or mental health decisions for me at times when I am unable to do so. These can include routine health care decisions (including life and death decisions) as well as mental health decisions. I will provide MultiCare with copies, or otherwise tell MultiCare where they are located.

GENERAL NOTICES AND ACKNOWLEDGEMENTS: I have been provided with a statement of my individual rights in my preferred language and understand that I can contact the receptionist or my therapist if I have questions. I have discussed the availability of local advocacy organizations that can assist me in understanding my rights. I have also have received a copy of this form and a list of the acts of unprofessional conduct and information on whom to contact should I wish to file a complaint.

I understand that firearms and other weapons are not allowed in any MultiCare Behavioral Health Network (MCBHN) facility and that I will be asked to leave the premises if I am in possession of a weapon.

I understand that the behavioral health agency is a tobacco, illegal substance, alcohol and marijuana free environment; these substances are not permitted on agency premises. The selling of or bartering for drugs (illegal, prescription, alcohol, etc.) are not permitted on agency premises. Individuals that appear to be under the influence of drugs/alcohol may be asked to reschedule their appointment and to leave the property.

This consent will remain in effect until such time my mental health and/or substance use disorder treatment services are terminated.

Please sign and date below:

**

Signature of Client/Legal Representative

**

Printed Name and Relationship

**

Date

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MultiCare Behavioral Health

Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider permitting real-time communication.

By signing this form, I am giving my consent to MultiCare Behavioral Health (MBH) to provide services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also applies to services provided to me via telemedicine.

I understand that Telemedicine Services can be discontinued at any time by myself or if it is determined by my provider that Telemedicine Services are no long appropriate. This information will be documented in my electronic health record. If Telemedicine Services are discontinued, I will receive phone only (telephonic) services, or in-person services when possible.

I understand that I need to be ready and on-time for all telemedicine appointments.

I understand that I need to be in a quiet, distraction free space during the session.

I understand that I will provide my telephone number at the start of the session, in case the telemedicine technology fails, and the session needs to continue by telephone.

I agree to notify my provider if I am having technological challenges related to my Telemedicine Services.

I understand that I have the right to file a grievance if I feel my rights are being violated, have a concern with the quality of care/treatment I am receiving or have any ethical concerns related to Telemedicine Services.

COMPLAINT PROCESS: 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.

Benefits, Restraints and Risks

MultiCare Behavioral Health (MBH) uses HIPAA compliant platforms for telemedicine. MBH has taken precautions to make Telemedicine Service delivery as secure as possible, however there are still some risks associated with virtual service delivery such as transmission interception or others around you overhearing session conversations.

If telemedicine technology fails, the call drops/unexpectedly ends, the provider will try to re-initiate the telemedicine session. Depending on the service type, if that fails, the provider will reach out via phone and provide a phone (telephonic) service instead. If that fails, the provider will reach out to you at a later time to reschedule the service.

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: ★ _____

Date: _____

CLIENT NAME (PRINTED): _____ **MRN:** _____ **DATE:** _____	Consent for Telemedicine Services Revised 11/30/2022

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MultiCare
Behavioral Health

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.

Please sign and date below:

* _____ * _____

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

* _____ * _____

Responsible Party / Parent / Legal Guardian signature: date

CLIENT NAME (PRINTED): _____ **MRN: _____ DATE: _____**	**CLIENT RIGHTS** **Revised 11/30/2022**

MultiCare
Behavioral Health

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 (PRINTED): _____ **MRN: _____ DATE: _____**	**CLIENT RIGHTS** **Revised 11/30/2022**

MultiCare Behavioral Health

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 this 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 (PRINTED): _____ **MRN: _____ DATE: _____**	Acknowledgment of Receipt of HIPAA Privacy Practices Revised 11/30/2022

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MultiCare
Behavioral Health Network

navos | Greater Lakes MENTAL HEALTHCARE

Important Notice About Your Health Records

The MultiCare Behavioral Health Network, comprised of Navos, Greater Lakes Mental Healthcare and MultiCare Behavioral Health, is part of the MultiCare Health System and shares a common Electronic Health Record platform. This means that **any MultiCare healthcare provider can access treatment records from any other MultiCare facility, department or provider.**

Because we are all part of the same health system, your MultiCare physician will be able to view your Substance Use Disorder or mental health records from Navos, Greater Lakes or MultiCare Behavioral Health. Your counselor or provider at any of our Behavioral Health Network organizations can also access information about your physical health from the MultiCare Health System.

This ability to share and access information across MultiCare allows us to provide high-quality, whole-person health that integrates all aspects of your healthcare, including physical, mental and Substance Use Disorder treatment.

MultiCare | Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE ALSO DESCRIBES YOUR RIGHTS AND SOME OBLIGATIONS MULTICARE HAS REGARDING THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

For purposes of this Notice, "MultiCare" or "we" means MultiCare Health System, including MultiCare Connected Care, Cardiac Heart and Vascular Institute, and members of the MultiCare Behavior Health Network: Greater Lakes Mental Healthcare and Navos.

MULTICARE'S PLEDGE AND RESPONSIBILITIES REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that information about you and your medical and behavioral 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 healthcare 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 health care. It includes your medical records and personal information such as your name, social security number, address, and phone number.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the practices of MultiCare and that of:

- Any health care professional authorized to enter information into your medical record 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.
- MultiCare Connected Care workforce members.
- 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, Auburn Medical Center, MultiCare Deaconess Hospital, MultiCare Covington Medical Center, MultiCare Valley Hospital, 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.

MULTICARE CONNECTED CARE NETWORK

MultiCare is part of the MultiCare Connected Care Network which is an organized healthcare arrangement (OHCA). AnOHCA 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 health and billing information about you with one another as may be necessary to carry out treatment, payment, and healthcare operations activities.

OTHERS WHO MAY ACCESS OR USE YOUR HEALTH INFORMATION

MultiCare participates 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). MultiCare also provides connectivity to its Electronic Health Record to independent community health care providers. As a condition of such access, each of these providers agrees to using information on a "need to know" basis and to comply with state and federal laws related to privacy and security.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Unless indicated otherwise, you may exercise one of your privacy rights by submitting a written request to 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 InformationManagement by phone 253-403-2423.

YOU HAVE A RIGHT TO:

Get an electronic or paper copy of your health record – Usually this includes treatment 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 (release of information) form or contact Health Information Management (medical records) at 253-403-2423. Greater Lakes and Navos medical records may also be requested via fax at 253-697-8393 or through BHMedicalRecords@multicare.org.
- 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 correct 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.

- We may say "no" to your request, but we'll tell you why in writing.

Request an accounting of certain disclosures – You may request an accounting of certain disclosures of your protected health information listing all the disclosures we made to others.

- This list will not include disclosures made 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 provider's front office staff and complete the Request for Restrictions form prior to being seen.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If we do agree to your request, we will comply unless the information is needed to provide emergency treatment to you.

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.

- We will say "yes" unless a law requires us to share that information.
- 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 or behavioral health 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 say yes to 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 ask the person to show proof of this authority toact 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.

- This Notice is also available online at www.multicare.org.

USES AND DISCLOSURE OF YOUR HEALTH INFORMATION BY MULTICARE

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

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.

In these cases we will not share your information unless you give us written permission (signed consent):

- Marketing purposes where remuneration is received
  - ~ 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 1-855-884-4284 or email annualgiving@multicare.org.
- Sale of your information
- Most sharing of psychotherapy notes
- Situations not described in this Notice that do not pose a threat to health or safety

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

- 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.

MultiCare typically will use your information in the following ways:

Treatment: We may use and disclose your protected health information to provide you with medical treatment and services and share it with other professionals who treat you.

- This use and disclosure may be for continuity of care or to doctors, nurses, technicians, health care students, or other health system personnel who are involved in your care.
- We may use and disclose your health information to different departments to coordinate activities such as prescriptions, lab work and x-rays and 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 and Idaho.

Payment: As permitted by law, we may use or disclose your health information to get payment from health plans and other entities.

- This includes billing for treatment and services you receive at a MultiCare facility.
- In addition, we may use or disclose your information to collect payment or to obtain prior approval for treatment and services.

Health system operations: We can use and share your health information to run our business, improve your care, and contact you when necessary.

- Running our business includes activities such as scheduling, infection control, administering the health plan, and population health activities.
- We may also use and disclose your information to other individuals (such as consultants and attorneys) and organizations that help us with our business activities.
- We may also use your health information for internal purposes, like ensuring the quality of care, identifying training needs, reviewing outcomes, sending patient satisfaction surveys, and other administrative activities.
- We may also disclose your information to Business Associates, or companies that provide a service to us or on our behalf and have provided satisfactory assurances that they will protect your health information.

MultiCare may also use your information in the following ways:

Public Health and Safety – We may disclose your health information to agencies when necessary, to support public health activities. 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.

Research – We can use or share your information for health research.

Limited Data Set Information – We may disclose limited health information to third parties for purposes of research, public health and health care operations. This limited data set will not include any information that could be used to identify you directly.

Comply with the Law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Organ and Tissue Donation – We can share health information about you with organ procurement organizations.

Coroners, Medical Examiners, and Funeral Directors – We can share health information with a coroner, medical examiner, or funeral director when a person dies.

Workers' Compensation – We can use or share health information about you for workers' compensation claims.

Government Requests and Law Enforcement – We can use or share health information about you:

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and Presidential protective services
- In limited circumstances, for law enforcement purposes or with a law enforcement official

Lawsuits and Disputes – We may disclose your health information 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.

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 – We may use or disclose information to tell you about or recommend possible treatment options or alternatives.

Health-Related Benefits and Services – We may use or disclose information to tell you about health-related benefits, services, or medical education classes.

Inmates – We may disclose your health information to a correctional facility or law enforcement official, if you are an inmate or in custody.

Incidental Disclosures – Certain incidental disclosures of your health information may occur as a byproduct of lawful and permitted use and disclosure of your health information. Reasonable safeguards are in place to minimize these disclosures.

Blood Conservation Services – We may use or disclose your health information if you have indicated affiliations with certain organizations and we believe you may be an ideal candidate who could benefit from blood conservation services.

Serious and imminent threats – We may share your information when needed to lessen a serious and imminent threat to the health or safety of you, the public, or another person.

SPECIAL INFORMATION TYPES

Washington, Idaho and federal law provide additional confidentiality protections in some circumstances. MultiCare generally may not release without specific authorization the following patient information:

- Washington — Specific sexually transmitted diseases
- State and federal law — Substance Use Disorder records that may be specially protected
- Washington — Behavioral health records that are specially protected in some circumstances

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 and 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.

CHANGES TO THIS NOTICE

MultiCare can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, at our facilities, and on our web site.

QUESTIONS AND COMPLAINTS

If you have general questions about this Notice, please contact the MultiCare Privacy Office by phone: 866-264-6121 or email: compliance@multicare.org. If you believe your privacy rights have been violated, you may file a 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. We will not retaliate against you for filing a complaint and the quality of your care will not be jeopardized.