Pathways
Treatment Center
Kalispell Regional Medical Center

NOTICE REGARDING VOLUNTARY ADMISSION

You have been admitted to Pathways Treatment Center on a voluntary basis. However, it is important that you know your legal rights regarding a voluntary admission. Per Montana Code Annotated §53-21-111, should you wish to terminate your admission prior to discharge by a physician, such a request must be made in writing. Your request may not be acted upon immediately, and you may be held involuntarily for up to 5 days after requesting release. In addition, the fact that you are here voluntarily does not impact your provider's ability to request involuntary commitment if your provider deems the same appropriate for your condition and mental health needs.

I acknowledge by signing below I am voluntarily applying to Pathways Treatment Center for admission and I confirm that I understand and agree to the terms of this notification.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Arrival Time

Patient Rights

1. The right to be free from discrimination
2. The right to receive a statement of your rights and have rights posted
3. The right to have confidential records maintained
4. The right of access to a patient advocate or lawyer
5. The right to be treated with dignity
6. The right to privacy
7. The right to freedom from unnecessary camera surveillance
8. The right to freedom from unnecessary searches
9. The right to a humane and safe environment
10. The right to comfort and safety
11. The right to receive visitors
12. The right to private telephone conversations
13. The right to send and receive mail
14. The right to wear your own clothing
15. The right to personal hygiene and grooming
16. The right to read books and materials of your own choice
17. The right to practice your religion
18. The right to an adequate diet
19. The right not to be photographed except for confidential identification unless you want to be
20. The right to regular exercise
21. The right to appropriate treatment
22. The right to prompt and adequate medical treatment
23. The right to a treatment plan
24. The right to participate in planning your own treatment
25. The right to be free from unnecessary restraint and isolation
26. The right to be free from abuse and neglect
27. The right to appropriate referral upon discharge
28. The right to freedom from unnecessary or excessive medication
29. The right to necessary informed consent
30. The right to file complaints
31. The right to an advanced medical directive

Full explanations of all your rights are available to you at the nursing station.

PATHWAYS TREATMENT CENTER – CERTIFICATION OF PATIENT RIGHTS

This is to certify that I have received a copy of the Summary of Patient Rights on the date indicated below. I understand that I am asked to read this information at my convenience and that I can discuss with Pathways Treatment Center staff any questions I have regarding the information provided.

Signature of patient: _____ Date: _____ Time: _____

Signature of Parent/Guardian: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

COMPLAINT/GRIEVANCE PROCEDURE:

If you cannot resolve your complaint with staff,
you have the right to submit a written complaint to the Patient Advocate.

- Write down your complaint.
- Give your note to the Charge Nurse, stating that you would like it to go to the Patient Advocate or you may call **406-751-5434.** Our Patient Advocate will talk to you about your complaint as soon as possible.
- An investigation will take place to learn all of the facts about your complaint.
- Every effort will be made to resolve the complaint.
- The Patient Advocate will speak to you about the outcome of the investigation.

PATHWAYS TREATMENT CENTER
200 HERITAGE WAY
KALISPELL, MT 59901

RELEASE OF INFORMATION

I understand that no one will be given the following information unless I give permission for them to be informed, except as prescribed by Law.

If the following persons contact the hospital requesting knowledge of my admission, treatment, progress and diagnoses, by this release, I give my permission to inform them as specifically designated below. I understand that I may revoke this release of information at any time and this form will be so noted with my signature. This release is only in effect as related to my present hospitalization.

Patient hereby grants Kalispell Regional Hospital, Kalispell Medical Imaging, Flathead Valley Radiology, Radiation Oncologist, and my Anesthesiologist authorization to release to my insurance company or companies and/or _____, and to all attending/consulting physicians, such medical and account information as may be necessary for the completion of hospital insurance claims for any other private or governmental claims relating to hospitalization, and further assigns my insurance benefits to the hospital for credit to my account.

Consent to Release Insurance Information to _____.
For use by insurance companies in processing claim for treatment, and assignment of benefits for services rendered by Pathways Treatment Center.

Emergency Contact Person: _____
Name

_____
Home # Work #

School Records (for Adolescents): _____
Name of School

_____
School Counselor

_____ _____
Patient Signature Date Time

_____ _____
Additional Signature and Relationship Date Time

_____ _____
Witness Signature Date Time

PATHWAYS TREATMENT CENTER
200 Heritage Way • Kalispell, MT 59901

RELEASE OF INFORMATION
EMERGENCY CONTACT / SCHOOL

8765-032C 5/95; 11/96; 7/98; 10/10

CONDITION OF ADMISSION

1. **CONSENT TO PHOTOGRAPH:** I agree to allow the hospital to take my photograph to be used for purpose of identification and for giving medications.

2. **VIDEO SURVEILLANCE:** The Behavioral Health Unit has constant video surveillance in common areas for patient safety.

3. **CONSENT TO SEARCH:** It has been explained to me, and I understand, that as a condition of admission to Pathways Treatment Center, that:
   - my belongings will be searched for alcohol, drugs, and contraband upon admission, after passes, and after visitors; and
   - a member of the hospital staff may search my clothing and my body for alcohol, drugs, and contraband upon admission, after passes, and after visitors; and
   - during my hospitalization searches will be initiated by staff at any time to ensure patient safety.

Witness	Date	Patient or Guardian	Date

I have conducted an authorized search of the patient's body, as well as the clothes he or she is wearing on admission as outlined in the Condition of Admission.

Staff Signature	Date

Pathways Treatment Center
KALISPELL REGIONAL HEALTHCARE
200 Heritage Way ~ Kalispell, MT 59901 Phone: (406)756-3950 Fax: (406) 756-3957

Patient Information: Name _____ DOB: _____ SSN: _____
Phone: _____ Fax: _____

Permission is hereby given to EXCHANGE information with:
Pathways Treatment Center
200 Heritage Way
Kalispell, MT 59901
Phone: 406-756-3950 Fax: 406-756-3957

AND: Organization/Facility/Person: _____
Street Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Health Information to be Released:
- ❑ Psychiatric Evaluation
- ❑ CD H&P
- ❑ IM H&P
- ❑ Psychological Report
- ❑ Discharge Summary
- ❑ Physician Orders
- ❑ Progress Notes
- ❑ Discharge Plan
- ❑ Medications
- ❑ Laboratory Reports
- ❑ ER Report
- ❑ Radiology Report
- ❑ Psychiatric Consult
- ❑ Assessments: Psychiatric Evaluation/Consult or CD H&P, IM H&P & Discharge Summary
- ❑ Other _____
- ❑ Pathways Treatment Center Packet: Demographic Sheet, Psychiatric Evaluation, Psychiatric Consult (if applicable) or CD H&P, IM H&P, CD Testing, Medications & Safety Plan

Type of Release: ❑ Verbal Exchange (no copies) ❑ Hard Copies (paper) ❑ Electronic/CD

Disclosure Method: ❑ Mail ❑ Fax_____ ❑ Pick up by patient/authorized designee (requires photo ID)

This information may be disclosed to and used by the above identified individual or organization: (Use additional forms if more than one recipient.)

Information to be used for the purpose of:
☐ Requested by Patient ☐ Continuum of Patient Care ☐ Other_____

Authorization:
- Copy Service Fee: I understand there will be a charge for copying records. The charge for copying records includes: a $15.00 Service Fee and 50 cents per page.
- I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and genetic information. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by CFR Part 2).
- This authorization does not apply to psychotherapy notes.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- If I fail to specify an expiration date, event or condition, this authorization will expire in six months. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
- I understand that, if I have been asked to sign this authorization by a healthcare entity that is covered by the HIPAA Privacy rules, I am to be given a copy of this signed authorization.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Patient Name_____ Patient Signature_____ Date_____
Parent/Legal Guardian Name_____ Parent/Legal Guardian Signature_____ Date_____
Witness Name_____ Witness Signature_____ Date_____

Revocation of Authorization – As noted in the Kalispell Regional Healthcare Joint Notice of Privacy Practices:
- I understand that I may revoke this authorization in writing at any time by contacting Pathways Treatment Center.
- I understand that if I revoke this authorization, this revocation will not apply to information that has already been released in response to this authorization.

I revoke (cancel) this Authorization to Disclose Health Information previously signed on: Date _____

Patient Name_____ Patient Signature_____ Date_____
Parent/Legal Guardian Name_____ Parent/Legal Guardian Signature_____ Date_____
Witness Name_____ Witness Signature_____ Date_____