Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

CLIENT NAME:_____SSN:_____DATE OF BIRTH:_____

ADDRESS (Mailing):_____CITY:_____STATE:_____ ZIP: _____

ADDRESS (Physical):_____CITY:_____STATE:_____ ZIP: _____

PHONE:(_____)_____ ☐ Text ☐ Voicemail EMAIL:_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced SEX: ☐ Male ☐ Female

BILLING INFORMATION ☐ If same as above check here

RELATIONSHIP TO PATIENT: _____

FIRST NAME:_____ MIDDLE INITIAL:_____ LAST NAME:_____

ADDRESS:_____CITY:_____STATE:_____ ZIP: _____

HOME PHONE: (_____) _____ WORK PHONE:(_____)_____CELL PHONE: (_____)_____

SSN: _____ DATE OF BIRTH _____

EMPLOYMENT INFORMATION

EMPLOYER'S NAME_____

OCCUPATION_____ BUSINESS ADDRESS_____

BUSINESS PHONE_____

INSURANCE INFORMATION

INSURANCE COMPANY_____

POLICY #_____GROUP #_____

POLICY HOLDER _____ SOCIAL SECURITY #_____ BIRTHDATE: _____

Appointments: A 24-hour notice on all appointment cancellations is required. If you do not give notice or NO SHOW, you will be billed $25.00. This charge is applicable regardless of payment type. After the second missed appointment, you will be required to pay a $25.00 non-refundable fee to book the appointment.

PAYMENT AGREEMENT I, the undersigned client/guardian, agree to pay for all services rendered to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

I certify that all the information that I have provided is true and correct to the best of my knowledge. I will notify you of any changes in my health status or in the above information. I have read and understand the above policies and agree to abide by these conditions.

_____ _____

SIGNATURE – PATIENT OR RESPONIBLE PARTY DATE

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

Personal Frontiers Disclosure Statement

Clinical Education and Licensures | Certifications

Counselors' credentials are available for inspection upon request.

Provider-Supervisor
Leslie Hayman
Professional Education
MSW, Social Work, University of WY
BA, Psychology, University of WY
Licensure Status
WY Licensed Clinical Social Worker -1386

Provider
Brenda Engle, PMHNP-BC
Professional Education
Licensed Advanced Psychiatric Nurse Practitioner, WY
ANCC Certified National Advanced Nurse Practitioner
Master of Science in Nursing- Regis College, Boston MA
Licensure Status
WY PMHNP-BC 38852.1580

Provider
Kristi Holum, MS, LPC
Professional Education
MS, Clinical Counseling
Bellevue University, NE
BA, Agriculture Education
Oklahoma State University
Licensure Status
WY Licensed Professional Counselor, LPC – 2032

Case Manager
Kim Krogman, AS, CAPA
Professional Education
AS, Addiction Studies
Casper College
Licensure Status
Certified Peer Specialist
WY Certified Addiction Practitioner Assistant, CAPA-72

Case Manager
Samantha Buck
Professional Education
AS, General Studies
Gillette College/NWCC
Certificate of Completion Addiction Studies
Licensure Status
Certified Peer Specialist
WY Certified Addiction Practitioner Assistant, CAPA-089

Case Manager
Timothy Blinkinsop
Professional Education
Gillette College
Studying Human Services
Licensure Status
Working on Peer Specialist Certification

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Professions Licensing Board. The Board can be reached at 2001 Capitol Avenue, Room 127, Cheyenne WY 82002, (307)777-7788. The Mental Health Professions Licensing Act requires this disclosure statement.

You are entitled to receive information regarding the counseling team credentials, the methods of therapy, the techniques used, the duration of your therapy (if known), and both the billing process and fee structure, which will be discussed with you by the Personal Frontiers, Inc. (PFI) Staff prior to beginning treatment. You may ask to have a different counselor, seek a second opinion from another therapist or terminate therapy at any time.

There is no designated time limit to services; however, it is the expectation that service frequency will decrease over time. The group, individual, and family services vary in intensity to meet the changing needs of individuals, families, and/or caregivers; to assist them in the home and community settings; and to provide a sufficient level of service as an alternative to the individual's need for a higher level of care. Your counselor also has the right to terminate therapy if he/she determines that (1) the relationship is no longer in the best interest of the client, (2) the client is a threat to the safety of the therapist or other clients at this agency, or (3) the client is consistently unwilling to follow the treatment plan agreed upon by the counselor and client during therapy.

In a professional relationship, sexual intimacy with a client is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

The information provided by and to you during therapy sessions is legally confidential and cannot be released without your written consent. However, the PFI clinical staff members work as a team and may disclose your information to one another to best support your treatment. As part of the standard training process, a Clinical Intern and Certified Addictions Practitioner Assistant provide counseling services under the direct supervision of PFI's designated qualified supervisor, who may hear information disclosed in your sessions to provide unlicensed practitioners with feedback and ensure that quality care is being provided. Please note, all information disclosed within sessions will be recorded and records will be maintained per federal and state regulations for seven (7) years before being destroyed in accordance with rules and regulations.

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

As of March 1, 1999, Wyoming has implemented a privileged communication statute. This law states that, when involved in legal proceedings (civil, criminal or juvenile) clients retain the right to privacy with the exception to the circumstances listed in W.S. 33-38-113:

- Abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected
- The validity of a will of a former client is contested
- Information related to counseling is necessary to defend against a malpractice action brought by a client
- An immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor
- In the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor
- The client alleges mental or emotional damages in civil litigation, or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation
- The patient or client is examined pursuant to a court order
- In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue

If a legal exception arises during therapy, if feasible, you will be informed accordingly.
However, it is PFI's heartfelt commitment to you and to your process that we maintain confidentiality in this relationship and adhere to the Code of Ethics of the American Counseling Association, American Association for Marriage and Family Therapy, and National Association of Alcoholism and Drug Abuse Counselors.

The confidentiality of alcohol and drug abuse patient records maintained by Personal Frontiers, Inc. is protected by federal law and regulations. Generally, PFI may not tell a person outside this organization that a client is participating in treatment or disclose any information identifying a client as an individual with a substance misuse problem unless:

- The client consents in writing
- The disclosure is allowed by a court order or
- The disclosure is made to medical personnel in a medical emergency

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Client or Responsible Party Signature: X_____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____

Complaints can be filed with:

Wyoming Department of Health
Office of Healthcare Licensing & Surveys
400 Quest Building
6101 N. Yellowstone Road
Cheyenne, WY 82002
307-777-7123 or wdh-ohls@health.wyo.gov
or visit health.wyo.gov/aging/hls/

OR

Wyoming State Board of Nursing
https://wybn.boardsofnursing.org/complaint

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

FINANCIAL POLICIES

The professional services provided by the agency are for your benefit. All fees charged by this agency are your responsibility. For your convenience we accept cash, check, MasterCard, Visa, and money orders.

Due at the time of service

Payment for Assessments, Intakes, Consults, Educational classes and Family Programming are due at the time of service unless prior arrangements have been made.

- All payment arrangements should be made before or at the time service is rendered. Should it be necessary to make payment arrangements, the following guidelines will be used:
- Should you need assistance in payment of your treatment care, please notify us immediately.

Insurance

We will bill any commercial insurance as a courtesy and make every effort to collect benefits on the insurer's behalf for a period of 90 days. After 90 days from the date of service, the account will be treated as a ***self-pay*** account, and you will be required to submit payment in full or make acceptable arrangements for payment. Professional care is provided to you, our client, not to an insurance company. Thus, the insurance company is ultimately responsible to you, the client, and you are responsible to the agency. For us to file your insurance, we need to be provided with **COMPLETE AND ACCURATE** insurance information to avoid delays in payment (i.e.: name, address, group, etc. of your primary insurance). Failure to provide us with correct information will result in you being responsible for your account. ***You are responsible for all fees not covered by your insurance company. This includes deductibles and co-pays.*** Our office cannot accept responsibility for negotiating a settlement on a disputed claim. If you dispute the amount of payment made by your insurance company, you should contact your insurance carrier, your human resources department, or your agent directly.

Medicaid Patients: Personal Frontiers, Inc. is a Wyoming Medicaid provider. If you are covered by Medicaid, you are required to provide your Medicaid ID Card before services for Medicaid to pay.

Financial options for clients without insurance:

Sliding Fee: A sliding fee scale may be available based on gross family income. Proof of income or non-income is required to qualify for sliding fees. Please let us know immediately if you would like to apply for the sliding fee schedule.

Grants: Each year Personal Frontiers applies for government grants to assist with the cost of treatment. To qualify you must have a gross family income at or less than 200% of the Federal Poverty Guidelines. If you feel you may qualify, please ask for a grant application.

Unpaid Accounts: Patients with unpaid delinquent accounts or accounts which have been written to bad debt or collection, may be denied treatment if the treatment is not deemed necessary.

Collections: Accounts over 90 days past due will be turned over to a ***collection agency*** unless prior arrangements have been made with the Director. I understand that if I fail to abide by this agreement, I relinquish my right to anonymity for the purpose of collection.

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payments directly to the above-named facility of the insurance for these services. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO PERSONAL FRONTIERS, INC. FOR CHARGES NOT COVERED BY INSURANCE OR DESIGNATED THIRD PARTY PAYEE.**

PAYMENT AGREEMENT

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 40% of the unpaid balance due.

A $25.00 fee will be assessed for any missed appointment without 24-hour notice of cancellation.

The undersigned certifies that having read the forgoing, received a copy thereof if requested, and is the patient or is duly authorized by the patient's general agent to execute the above and accept its terms.

_____
Print Name

X_____ / _____ / _____ / _____
Signature of Client or Client's Representative: Date Time Relationship

Witness_____ / _____ / _____
Signature Represents Witness for Entire Document Date Time

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

NOTICE OF PRIVACY POLICIES AND 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.

Effective: April 14, 2003

Your information will only be released in accordance with state and federal laws and the ethics of the American Counseling Association, American Association for Marriage and Family Therapy, and National Association of Alcoholism and Drug Abuse Counselors. The following notice describes Personal Frontiers, Inc. policies related to the use and disclosure of the client healthcare information.

CONFIDENTIALITY

You have the right to confidentiality as protected by Federal Regulation (C.F.R. 42 part 2 and C.F.R. 45) which prohibits disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations, except in cases of imminent life threatening physical danger to the client or others, instances of legally reportable child and adult abuse and/or neglect, and to qualified state and federal personnel and to authorized peer reviewers, consultants and supervisors under written oath of confidentiality. Also, under W.S.33-18-113, privileged communications, the client and counselor may refuse to disclose and prevent the disclosure of confidential communication. All sessions and written records pertaining to counseling are held in strictest confidence. Personal Frontiers, Inc. (PFI) Clinical Staff reviews cases weekly and your information may be shared among the listed counselors on the disclosure statement.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

Personal Frontiers, Inc. may use or disclose your protected health information for treatment, payment, and health care operations purposes with your consent.

- "Protected health information" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
    1. Treatment is services provided, managed, or coordinated related to your health care and other services, including consultation and referral sources, related to your health care.
    2. Payment is when PFI verifies your insurance coverage and processes claims to collect fees or obtains reimbursement for your healthcare. Examples of payment are when PFI discloses your protected health information to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    3. Health Care Operations are activities that relate to the performance and operation of the practice of PFI. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within PFI such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of PFI, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

PFI may use or disclose protected health information for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when PFI is asked for information for purposes outside of treatment, payment and health care operations, an authorization will be obtained from you before releasing this information except in situations described below. Your clinical team will also need an authorization before releasing psychotherapy notes of private counseling sessions, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than protected health information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) information was already obtained or released (used or disclosed) prior to the revocation; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

PFI may use or disclose protected health information without your consent or authorization in the following circumstances:

- Child Abuse: If PFI knows or has reasonable cause to believe or suspect that a child has been abused or neglected, or if PFI staff observe any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, PFI must immediately report it to the field or regional offices of the Wyoming Department of Family Services or local law enforcement agency or cause a report to be made.
- Adult and Domestic Abuse: If PFI staff have reasonable cause to believe that an elderly or disabled adult is being or has been abused, neglected, exploited, or abandoned, or is committing self-neglect, staff members are required by law to report such information immediately to a law enforcement agency or to the Wyoming Department of Family Services.
- Health Oversight: If you file a complaint against a clinical staff member with the Mental Health Professions Licensing Board, PFI staff may disclose to them confidential mental health information that is relevant to that complaint.
- Judicial or administrative proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and PFI will not release such information without written authorization from you or your legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

- Serious Threat to Health or Safety: PFI shall not disclose any information communicated for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, in the absence of an express waiver of the privilege except where an immediate threat of physical violence against a readily identifiable victim is disclosed to a PFI staff member.
- Workmen's Compensation: If you file a worker's compensation claim, that is a release of information for the duration of the benefit period, and upon request and upon notice to you, PFI must release mental health records pertaining to your injury to the Wyoming Workmen's Compensation Division or your employer.
- National Security: Protected health information may be disclosed to authorized federal authorities for national security or intelligence purposes or to correctional institutions or law enforcement officials who have lawful custody of such information of the inmate or patient under certain circumstances.

Access to Confidential Information by: Agency Personnel, Outside Funding Sources and Multidisciplinary Teams

- Staff of PFI including therapist, administrative staff and volunteers may have access to protected health information for purposes of performing their duties only and are restricted from releasing any information without the expressly authorized consent of the client.
- PFI is subject to the oversight of certain State and Federal funding sources whose contracts may require them to have access to certain records for audit purposes. Any authorized personnel of such agencies will sign a confidentiality statement prior to having access to any client information.
- In some cases where a multidisciplinary team may collaborate to provide comprehensive treatment to a patient and family for the purpose of diagnosis or treatment, the client will be asked to sign a release for the team.

Client Rights

- Restrictions: You have the right to request restrictions on certain uses and disclosures of your protected health information. However, these requests must be in writing and PFI is not required to agree to a restriction you request.
- Alternative Communications: You have the right to request and receive confidential communications of protected health information by alternative means and at alternative locations. (Example: You want bills sent to another address for privacy reasons.) This request must be in writing, specify the alternative means or location, and give a satisfactory explanation.
- Inspect and Copy: You have the right to request to inspect or obtain a copy of protected health information if this information is maintained in the record. PFI may deny your request under certain circumstances, but in some cases, you may have this decision reviewed. Requests must be made in writing. There is a charge for copies of records. At your request, PFI will discuss with you the details of this process.
- Amendment: You have the right to make a written request for an amendment of your protected health information. This request must include an explanation as to why the information should be amended. PFI may deny your request. At your request, PFI will discuss with you the details of the amendment process.
- Accounting: You generally have the right to receive an accounting of disclosures of protected health information regarding you for the past six years but not before April 14, 2003. At your request, PFI will discuss with you the details of the accounting process.
- Paper Copy: You have the right to obtain a paper copy of this notice.
- Filing a complaint: You have the right to file a complaint in writing with the PFI Executive Director or with the Office of Civil Rights.

Clinical Staff Duties:

Each clinical staff member is required by law to maintain the privacy of protected health information and to provide you with a notice of legal duties and privacy practices with respect to it. Clinical staff members reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, clinical staff members are required to abide by the terms currently in effect. If policies and procedures are revised, this notice will be changed and made available upon request.

Complaints

If you are concerned that a PFI staff member has violated your privacy rights, or you disagree with a decision made about access to your records, please discuss it with PFI Clinical Director or you may file a written complaint with the Executive Director. You may also file a complaint with:

Mental Health Professionals Licensing Board
2001 Capitol Ave., Room 105
Cheyenne, WY 82002
P: (307) 777-7788 • F: (307) 777-3508

I have read the preceding information and understand my rights as a client or client's responsible party.

_____
Print Name

X_____ / _____ / _____ / _____
Signature of Client or Client's Representative: Date Time Relationship

Witness_____ / _____ / _____
Signature Represents Witness for Entire Document Date Time

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

CLIENT RIGHTS STATEMENT

As a client of Personal Frontiers, Inc., you have the following rights:

- to be entitled to respect and dignity in an environment that affords security and privacy;
- to receive services that are protected under the laws of confidentiality and to receive a Privacy Notice as well as other information concerning your rights in regard to the use, storage, and disclosure of healthcare information;
- to receive services regardless of race, sex, national origin, creed, physical or mental handicap, or personal ability to pay;
- to know the reasons for or purpose of the services provided and to consent to receiving these services;
- to receive an individual evaluation and treatment based upon your needs, abilities, and goals, including your active participation in the development of your individualized treatment plan;
- to ensure that your needs and preferences are not neglected and to receive any information needed to make informed decisions concerning the services you receive;
- to ensure your fees are adequately and fairly assessed;
- to express your preferences concerning the choice of service provider;
- to review your records upon reasonable request and as provided by law;
- to refuse treatment or withdraw from services at any time;
- to be free from physical abuse, sexual abuse, harassment, and physical punishment imposed by program employees;
- to be free from psychological abuse, including humiliating, threatening, and exploitive action on the part of program employees;
- to be free from fiduciary abuse associated with program employees holding in trust anything of value that belongs to you;
- to be informed of and treated in compliance with the DOT regulations; and
- to receive assistance from the program in facilitating a referral to recommended services.

CONSENT TO TREATMENT

I certify that my rights have been fully explained to me. I agree to each of them and remain desirous of treatment services provided by this program in accordance with these rights.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

Communicable Disease Acknowledgment

Due to high risk life style factors, the Wyoming Department of Health requires that we offer you information about communicable diseases**.**

PLEASE CHECK ONE OF THE FOLLOWING:

_____ I feel that my life style IS SUCH that I need to be referred.
(Unprotected sex with partners of unknown sexual history, IV drug use, etc.)

_____ I feel that my life style HAS NOT put me at risk and I do not need tested.

I have read, discussed, and have been given a brochure upon request outlining communicable Diseases.

_____ _____
Client Signature Date

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

Personal Frontiers, Inc
Informed Consent for Telemed Services

Telemedicine involves electronic communications to enable health care providers at separate locations to share individual patients' medical information to improve patient care. Providers may include primary care practitioners, counselors, social workers, specialists, peer specialists, and/or case managers. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical imaging
- Live two-way audio and video
- Output data from medical services and sound and video files
- Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected benefits

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the nurse practitioner and/or licensed counselor, and/or provisional clinical social worker, obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for proper medical decision making by the nurse practitioner and/ or licensed counselor, and/ or provisional clinical social worker, and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In exceedingly rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgement error.

By signing this form, I attest to and understand the following:

1. I understand the laws which protect the privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which may identify me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all the information obtained and recorded during telemedicine interaction, and may receive copies of this information for reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.
6. I understand that it is my duty to inform the program of electronic interactions of my care that I may have with other healthcare providers.
7. I understand that I may expect the benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am in the state of Wyoming and will be present in the state of Wyoming during all telehealth encounters.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above about telemedicine, have discussed it with my nurse practitioner and/or licensed counselor, and/or case manager, and consultant(s) or such designated assistants, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for print.

I hereby authorize Personal Frontiers and Center for Solutions specialist to use telemedicine during my diagnosis and treatment.

Patient Signature or Legal Guardian Date Time

Print Legal Name or Legal Guardian Relationship

Witness Signature Date

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

LEGAL INFORMATION
(if applicable)

For us to best help you through the legal system please provide the following information:

Are you here today due to a violation of a law? YES NO

COURTS:

Do you have a court date? YES NO

Date:_____

Have you been ordered by a Judge to be here? YES NO

If YES:
Date of Court Order: _____

Which Court did you appear in? District Circuit Municipal (City)

City_____ State_____

ATTORNEY:

Do you have an Attorney? YES NO

IF YES:
Is your Attorney a Public Defender? YES NO

Did your Attorney refer you here? YES NO

Attorney's Name: _____

Contact Information: _____

PROBATION/PAROLE:

Are you currently on Probation or Parole? YES NO

If YES:
Supervised: _____ Unsupervised: _____
Adult: _____ Juvenile: _____
State: _____ Federal: _____

What Jurisdiction office are you under? County_____State_____

What is the name of your current Probation/Parole Officer? _____

DEPARTMENT OF FAMILY SERVICES (DFS)

Were you referred/required to be here by DFS? YES NO

IF YES:
Who is your Case Worker? _____

VOA HALFWAY HOUSE

Are you a resident of the VOA in Gillette? YES NO

IF YES:
Who is your Case Worker?_____

DEPARTMENT OF TRANSPORTATION

Did the DOT refer you here? YES NO

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

INTENTIONALLY LEFT BLANK

Personal Frontiers, Inc.
- Est. 1976 -
Recover Your Life
Wyoming Certified Provider

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

Check the appropriate answer for each section.

Date _____

Gender	
	Male
	Female
	Other: _____

Age	
	17 & Under
	18 - 23
	24 - 44
	45 - 54
	55 - 69
	70 or older

Ethnicity	
	Hispanic, Latino or Spanish Orgin
	Not Hispanic, Latino or Spanish Orgin

Race	
	White
	Black/African American
	American Indian/Alaska Native
	Asian
	Native Hawaiian/Other Pacific Islander
	Other:_____
	Multi Race (any 2 or more)

Education Level	
	0-8
	9-12 (non-graduate)
	High School Diploma/GED
	12+ Some Post Secondary
	2 or 4 year graduate

Other Characteristics (yes or no)	
y n	Health Insurance
y n	Disabled
y n	Veteran

Family Type	
	Single Parent Female

Family Size	
	One
	Two
	Three
	Four
	Five
	Six
	Seven
	Eight or More

Source of Family Income	
	TANF
	Social Security
	Pension
	General Assistance
	Unemployment Insurance
	Employment + Other Sources
	Employment Only
	Other

Estimated Household Annual Income	
	0-$10,000
	$10,001 to $20,000
	$20,001 to $30,000
	$30,001 to $40,000
	$40,001 to $50,000
	$50,001 to $60,000
	$60,001 to $70,000
	$70,001 and over

Housing	
	Own
	Rent
	Homeless
	Other

Where Do You Live?	
	Gillette (In City Limits)
	Campbell County
	Wright

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716
Mailing: PO Box 754 • Gillette, WY • 82717
P: 307-686-1189 • F: 877-502-2977

	Single Parent Male
	Two Parent Household
	Single Person
	Two Adults NO Children
	Other:

	Other: _____

Referral Source	
	Attorney
	Probation & Parole
	Courts
	DFS
	Counselor
	Other:_____