SEQUOIA
detox centers

PATIENT REFERRAL PACKET

FAX TO: (509) 315-9386

SENDING FACILITY: ____

CONTACT NAME: ____________________ CONTACT PHONE NUMBER: ____________

Confidentiality Notice: The information contained in this transmission is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). This transmission is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, dissemination, distribution, printing or copying of this transmission is strictly prohibited and may subject you to criminal or civil penalties. If you have received this transmission in error, please contact the sender immediately by replying to this email and deleting this email and any attachments from any computer.

RELEASE OF INFORMATION

SEQUOIA detox centers

PATIENT INFORMATION

FIRST NAME: ______________________ LAST NAME: ______________________

BIRTHDATE: _____ /_____ /_________ PHONE NUMBER: ________ - __________ -______________

FIRST PARTY

INDIVIDUAL/ COMPANY NAME	ADDRESS	PHONE NUMBER	EMAIL/FAX NUMBER

SECOND PARTY

INDIVIDUAL/ COMPANY NAME	ADDRESS	PHONE NUMBER	EMAIL/FAX NUMBER
Sequoia Detox Centers	10305 E Montgomery Drive	(509) 418-2108	sequoia.help@sequoiadetoxcenters.com
	Spokane Valley, WA 99206		(509) 315-9386

☐ RELEASE INFORMATION FROM 1ST PARTY TO 2nd PARTY
☐ RELEASE INFORMATION FROM 2ND PARTY TO 1ST PARTY
☐ MUTAL SHARING INFORMATION BETWEEN 2ND PARTY AND 1ST PARTY

INFORMATION TO RELEASE/RECIEVE

____
PATIENT INITIALS

All information in record including, but not limited to history, diagnosis, progress in and/or response to treatment and prognosis.

____
PATIENT INITIALS

All information in record *EXCLUDING*:

☐ Information relating to my HIV, AIDS, or STD status
☐ Evaluation Results
☐ Treatment Recommendations
☐ Discharge Summary
☐ Progress Notes
☐ Medication Information
☐ Group Notes

☐ Other____

REASON TO RELEASE/RECEIVE INFORMATION

☐ Evaluation ☐ Treatment/discharge planning ☐ Coordination of care

EXPIRATION OF DOCUMENT

This release of information is valid for *90 days past the date of discharge* from Sequoia Detox Centers; or by the date, event, or condition specified below:

____

PATIENT AUTHORIZATION

I authorize the receipt or release of psychiatric records, mental health records, drug and alcohol records and HIV/STD related information as applicable. I understand that my records are protected under the Federal/State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my consent is subject to a written revocation by me at any time except to the extent that action has been take in reliance on it (e.g. court related, probation, parole, etc.)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires automatically as described above unless further release is authorized by law.

I acknowledge that the information to be released was fully explained to me, and this consent is given voluntarily by me of my own free will.

PRINTED NAME OF PATIENT ____________________ DATE ____________________

PATIENT/LEGAL GUARDIAN SIGNATURE ____________________ INITALS OF STAFF ____________________

This notice accompanies a disclosure of information concerning a patient in alcohol/drug treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2.

The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person of whom it pertains or as otherwise permitted by 42 CFR, Part 2.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NEW PATIENT APPLICATION

SEQUOIA detox centers

Patient demographics are a critical part of our admission process. By creating a consistent process for collecting this information, Sequoia's providers can take steps to ensure all patients have the potential to reach optimal treatment outcomes during their stay with us. Sequoia Detox Centers will not sell or distribute this information per 42 CFR Part 2.

PATIENT DETAILS

FIRST NAME: ______________________ LAST NAME: ______________________

PREFERRED NAME: ______________________________

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SOCIAL SECURITY NUMBER: ________ - ________- ________

SEXUAL ORIENTATION: ☐ Straight or Heterosexual ☐ Lesbian, Gay or homosexual

☐ Bisexual ☐ Don't Know ☐ Choose not to disclose

☐ Something else, please describe: ______________________________________

GENDER IDENTITY: ☐ Female ☐ Male ☐ Female-to-Male/Transgender

☐ Male-to-Female/Transgender ☐ Genderqueer ☐ Choose not to disclose

RACE GROUP *(select up to 4):* ☐ American Indian or Alaska Native ☐ White/Caucasian

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

☐ Other Race

PRIMARY RACE (*List up to 4*): ______________________________________

____

____

ETHNICITY GROUP: ☐Not Hispanic/Latino ☐ Hispanic/Latino

ETHNICITY (COUNTRY OF ORIGIN): ______________________________________

PREFERRED LANGUAGE: ______________________________________

EMPLOYER/SCHOOL DETAILS

OCCUPATION/INDUSTRY: ____

CURRENT OCCUPATION STATUS: ☐ Full-Time (35+ hr/wk) ☐ Part-Time (less than 35 hr/wk)

☐Self- Employed ☐ Unemployed ☐ Laid Off ☐ Retired ☐ Stay-at-home Parent

HIGHEST LEVEL OF EDUCATION *COMPLETED*: ☐Last grade completed: ______ *(if no GED/Diploma)*

☐High School Diploma ☐GED ☐Some College *(no degree)*

☐ Undergraduate (Associate's Degree) ☐ Undergraduate (Bachelor's Degree)

☐ Graduate (Master's Degree) ☐ Graduate (Doctoral Degree)

BILLING INFORMATION

PREFERRED PAYMENT METHOD: ☐Pay privately *(10% discount for full payment upfront)* ☐Bill insurance

If billing insurance:

INSURANCE PROVIDER: ______________________________________ STATE: ________

MEMBER ID: ________________________ GROUP NUMBER: ______________________

MEMBER SERVICES PHONE NUMBER: ___________________________

If insurance covered under someone other than patient:

NAME OF RESPONSIBLE PARTY: ____

SOCIAL SECURITY NUMBER: ________ - ________- ________ BIRTHDATE: ______________

BILLING ADDRESS: ____

CITY: ____________________________ STATE: _________ ZIP CODE: ______________

HOW DID YOU HEAR ABOUT SEQUOIA DETOX CENTERS?

☐ Google Search ☐ TV ☐ Instagram/Facebook ☐ Newspaper/Magazine/Poster

☐ Podcast/YouTube ☐ Referred by a friend/family member ☐ Referred by a Care Provider

I hereby request psychological and psychiatric services from Sequoia Detox Centers. I understand that this formal request for services is for licensed and/or certified care under WAC 388-865, which details the types and manner of treatment I may receive.

This request is made completely voluntarily and in no way limits my ability to seek help for myself from other medical services, social care agencies, private sector providers or natural care givers.

By signing below, I acknowledge I have completed the questions outlined above accurately and to the best of my ability.

____ ____________

PRINTED NAME OF PATIENT DATE

____ ____________

PATIENT/LEGAL GUARDIAN SIGNATURE INITALS OF STAFF

PATIENT HEALTH HISTORY

SEQUOIA
detox centers

Your health history is a critical part of our admission process. By giving us this information, Sequoia's providers can ensure you receive the best care possible. Sequoia Detox Centers will not sell or distribute this information per 42 CFR Part 2.

CURRENT ADDICTION

WHAT SUBSTANCE(S) ARE YOU CURRENTLY STRUGGLING WITH?

☐ Alcohol ☐ Amphetamines (Meth, Ice, Crank) ☐ Cocaine/Crack ☐ Hallucinogens

☐ Heroin ☐ Marijuana ☐ Opioid Pain Medications ☐ Inhalants

☐ Sedatives (*Benzos, Sleeping Pills*) ☐ Over-the-Counter medications ☐ Nicotine

☐ Other:____

HOW OFTEN ARE YOU USING?

☐ Multiple Times per day ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially

ABOUT HOW LONG HAVE YOU BEEN USING THOSE SUBSTANCES?

☐ 1 – 3 months ☐ 6-12 months ☐ 2 -4 years ☐ 5 or more years

MEDICAL INFORMATION

DO YOU HAVE ANY ALLERGIES? ☐ NO ☐ YES

IF **YES**, List Allergies:

ALLERGY	REACTION

DO YOU HAVE ANY CHRONIC MEDICAL CONDITIONS? ☐ NO ☐ YES

IF **YES**, List conditions:

CONDITION	AGE OF ONSET/DIAGNOSIS

ARE YOU CURRENTLY BEING PRESCRIBED ANY MEDICATIONS? ☐ NO ☐ YES

IF YES, List medications:

MEDICATION	DOSAGE	FREQUENCY

HAVE YOU EVER HAD MEDICAL COMPLICATIONS BECAUSE OF YOUR DRUG OR ALCOHOL USE?
(i.e. memory loss, hepatitis, convulsions, bleeding, etc.) ☐ NO ☐ YES

IF YES, List complications:

COMPLICATION	DATE(S)	DID YOU RECEIVE MEDICAL TREATMENT?
		☐ NO ☐ YES
		☐ NO ☐ YES
		☐ NO ☐ YES
		☐ NO ☐ YES
		☐ NO ☐ YES

By signing below, I acknowledge I have completed the questions outlined above accurately and to the best of my ability.

PRINTED NAMEOF PATIENT

DATE

PATIENT/LEGAL GUARDIAN SIGNATURE