Wolf Pack
Consulting and Therapeutic Services, LLC
(p) 503.828.3402
(f) 503.828.3401
contact@wolfpackcts.org

Notice of Privacy Practices

This notice describes how your health information may be used, disclosed, and how you can get access to this information.

Please review this carefully.

This notice applies to Wolf Pack Consulting and Therapeutic Services, LLC and each associated provider, which collectively form an organized health care arrangement. This means that Wolf Pack Consulting and Therapeutic Services, LLC and associated providers may share your health information, as described in this notice and as authorized by you. This notice contains additional details regarding how your information may be shared.

All communications regarding your rights or this notice may be directed to:

Wolf Pack Consulting and Therapeutic Services, LLC
Attn: Molly Griffith, Privacy Officer
In Person: 16365 NW Twin Oaks Drive 200 Beaverton, OR 97006
Mailing: 16055 SW Walker Road #443 Beaverton, OR 97006
(phone) 503.828.3402 (fax) 503.828.3401

Your Rights

You have the right to:

- Get a copy of your paper or electronic health records
- Correct your paper or electronic health records
- Request confidential communication
- Ask this agency to limit information that we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have choices in the way that we use and share your information. These choices may pertain to:

- Telling family and friends about your condition
- Providing mental health care
- Marketing our services

Our Uses and Disclosures

We may use and share your health information as we:

- Provide treatment
- Run our organization
- Bill for services provided to you
- Help with public health and safety issues
- Comply with the law or address government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities.

- You have the right to an electronic or paper copy of your health records. It is our goal to provide this to you within 30 days of your request. We may charge a reasonable and cost-based fee.
- You have the right to ask us to correct your health record.
- We may deny your request and we will provide a writing explanation within 60 days of your request.
- You have the right to request confidential communications.
- You have the right to choose how this agency will communicate with you (for example, via your home or office phone, or email) within the limits of all reasonable requests.

- You have the right to limit what we use or share pertaining to your health information for treatment, payment, or our operations. We have the responsibility to deny your request for limitation if it would affect the success of your care.
- Your prior written authorization is required to use or share certain sensitive mental health information. Wolf Pack Consulting and Therapeutic Services, LLC will ask you for this authorization upon starting services with our agency, due to the integrated nature of our services. You have the right to refuse this authorization or you may revoke an authorization that you have previously granted us at any time.
- If you have paid for a service or health care item out-of-pocket in full, you may request that this agency not share information related to your care for the purpose of payment or our operations with your health insurer. This agency will comply with your request unless a law requires that such information be shared.
- You have the right to a list of those with whom we have shared your information and the reason for such disclosure of information. This list will include information shared for up to six years prior to the date the request was made. We will include all disclosures, with the except of those pertaining to treatment, payment, health care operations, and other information the client requests to be excluded. We will provide one accounting per year at no charge. For any additional accounts within 12 months, there will be a reasonable, cost-based fee.
- You have a right to a paper and electronic copy of this privacy notice. This will be provided in a prompt manner.
- You have the right to choose another individual to act for you.
- If another individual is your legal guardian or has medical power of attorney, that individual can exercise your rights and make choices about your health information. Before allowing such action, this agency will confirm through writing their relationship to you.
- You have the right to file a complaint with our agency, if you feel your rights are violated. Please see Page 1 of this notice for the proper process to file a complaint. You can also file a complaint with the Oregon Bureau of Labor and Industries at 800 NE Oregon St, Suite 1045, Portland, OR, 97232. The office phone number at this location is 971-673-0764. More information regarding how to file a complaint can be found at: https://www.oregon.gov/boi/CRD/pages/c_crcompl.aspx. Additionally, you can file a complaint with the Oregon Department of Human Services by sending a letter to the Governor's Advocacy Office at: 500 Summer St. NE, E17, Salem, OR 97301-1097, or calling 1.800.442.5238.
- Please be aware that this agency will not retaliate against you in the event that you file a complaint.

Your Choices

You have the right to choose what health information is shared and your information is shared related to the following:

- Marketing purposes
- Mental health and/or substance abuse treatment progress notes

Please be aware that further rules apply to "psychotherapy notes." A psychotherapy note is documented information (in any medium) by a mental health professional regarding the content of conversations during a mental health counseling session for an individual, couple, family, or group. Psychotherapy notes exclude medication management, counseling session start and stop times, modalities and frequencies of treatment completed, results of clinical testing, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Specifically, we may not be able to share psychotherapy notes without your written permission except for:

- Use by the originator of the psychotherapy note for treatment
- Use or disclosure by your provider for its own training programs
- Use or disclosure by your provider to defend itself in a legal action or other proceeding

In order to provide you joint treatment, to provide you access to associated health care providers on nights and weekends or in emergencies, to improve the quality of care provided at Wolf Pack Consulting and Therapeutic Services, LLC, and to facilitate operations, we will ask your permission to disclose your mental health information, including any psychotherapy notes, between Wolf Pack Consulting and Therapeutic Services and its associated health care providers. Even with your authorization, we will not disclose any more of your mental health information than the minimum amount necessary.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat You

- We can use your health information and share it with other professionals who are treating you. **EXAMPLE**: If you see multiple health care providers through Wolf Pack Consulting and Therapeutic Services, LLC, those providers will be able to share your health information to coordinate treatment.

Run Our Organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. **EXAMPLE**: We use health information about you, such as when you have an appointment scheduled or your diagnosis, to manage your treatment services.

Bill for Your Services

- We can use and share your health information to bill and get payment from health plans or other entities. **EXAMPLE**: We give information about you to your health insurance plan so it will pay for the services you receive from Wolf Pack Consulting and Therapeutic Services, LLC.

How do we typically use or share certain mental health information? Because there are special rules regarding the use and disclosure of certain mental health information, including psychotherapy notes, as discussed in detail on pages 1-2 above, we will use or disclose certain mental health information as you authorize us. If you have authorized us to share your mental health information, including any psychotherapy notes, we can disclose that information to associated health care providers as necessary.

EXAMPLE: Upon intake, you sign a form authorizing Wolf Pack Consulting and Therapeutic Services, LLC and any associated health care provide to disclose your mental health information as necessary for treatment, payment, and operations. Later, when you have an emergency and need to see a different counselor through Wolf Pack Consulting and Therapeutic Services, LLC than you would usually see, your usual counselor can disclose your mental health information to this different counselor so that you can receive treatment.

EXAMPLE: Upon intake, you sign a form authorizing Wolf Pack Consulting and Therapeutic Services, LLC and any associated health care provider to disclose your mental health information as necessary for treatment, payment, and operations. Later, if Wolf Pack Consulting and Therapeutic Services, LLC determines that it needs certain mental health information in order to secure payment for the services provided to you, your counselor can disclose this information to Wolf Pack Consulting and Therapeutic Services, LLC, which can then disclose this information as necessary to secure payment.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with Public Health and Safety Issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Preventing disease

Comply with the law

We will share information about you if state or federal law requires it, including the U.S. Department of Health and Human Services, the Oregon Department of Human Services, or other such state agencies with appropriate authority to ensure that this agency is in compliance with federal and state privacy law.

Work with a Medical Examiner or Funeral Director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies, if necessary. Additionally, if this agency needs to address workers' compensation, law enforcement, or other government requests.

We can use or share health information about you:

- For workers' compensation claims

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

Respond to Lawsuits with Legal Actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly 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.

For more information see: www.hhs.gove/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Organized Health Care Arrangement

Wolf Pack Consulting and Therapeutic Services, LLC is a legally separate entity from the counselors and mental health care providers who work with (or in other words, who are associated with) Wolf Pack Consulting and Therapeutic Services, LLC. However, Wolf Pack Consulting and Therapeutic Services, LLC and its associate providers share office space, are operationally integrated (i.e., administration, management, and billing are all accomplished through Wolf Pack Consulting and Therapeutic Services, LLC), hold themselves out to the public as a joint enterprise, and engage in joint activities, such as providing joint treatment and engaging in joint quality improvement and assessment activities. As such, Wolf Pack Consulting and Therapeutic Services, LLC and its associated providers form an organized health care arrangement, allowing these legally separate entities to share this notice and share other health information as allowed by law. Notably, you may need to authorize disclosure of certain mental health information before that information can be shared between entities within the organized health care arrangement. You will be asked to sign an authorization allowing the entities within the organized health care arrangement to share certain mental health information when necessary. If you have any questions about the organized health care arrangement, please ask us.

Changes to the Terms of this Notice

We 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 and in our office.

Effective Date of this Notice

This notice is effective as of June 1, 2017.

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Informed Consent

Mental health therapy, care coordination, and skill building transpire relationships that work in part because of clearly defined rights and responsibilities held by each party involved. As a client in services, you have certain rights that are important for you to understand in order to meet the goal of your well-being. Please be aware that there are limitations to those rights. Additionally, we have corresponding responsibilities to you, the client.

OUR RESPONSIBILITIES TO YOU

A. CONFIDENTIALITY

The client has the right to the confidentiality of the services received. Without your prior written consent, this agency cannot disclose your information for status as a client to other parties. Under the provisions of the Health Care Information Act of 1992, providers of this agency may speak to another health care provider or a member of your family about your treatment without your prior consent in the case of psychiatric or medical emergency. This agency will always act to protect your privacy, including in the case that the client has signed a release of information. The client may direct a provider to share information with whomever chosen by the client, and this permission can be revoked at any time. Additionally, the client may request to have others present in a therapy session over the course of treatment. As a client, your information is protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). If you are receiving treatment for substance abuse, your privacy is protected by Federal Regulation 42 CFR Part 2.

The following are legal exceptions to the client's right to confidentiality. The client will be informed if these exceptions have been utilized.

1. If we have good reason to believe that you will harm another person, we must attempt to inform that person and warn them of your intentions. We must also contact the police and ask them to protect your intended victim.
2. If we have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give us information about someone else who is doing so, we must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If we believe that you are in imminent danger of harming yourself, we may legally break confidentiality and call the police or the pertaining county crisis team. We are not obligated to do this, and would explore all other options with you before we took this step. If at that point you were unwilling to take steps to guarantee your safety, we would call the pertaining county crisis team.

B. RECORD KEEPING

We keep brief records of each session noting the date of meeting, topics covered, progress from the client's perspective, interventions used, therapist's and skill builder's impressions, and future treatment goals. Our records are kept secure and private so that only appropriate parties have access to them, in accordance with HIPPA and 42 CFR Part 2 requirements.

C. DIAGNOSIS

If a third party, such as an insurance company, is paying for part of the client bill, this practitioner is required to give a diagnosis to that third party in order to be paid. Diagnoses are clinical terminology to describe the nature of your needs, and they may include a description of such needs as being either short-term or long-term. It is a client's right to know the stated diagnosis by a provider and the nature of that diagnosis.

D. OTHER RIGHTS

You have the right to ask questions about anything that occurs over the course of treatment. Providers at this agency are always willing to discuss how and why decisions regarding treatment are made. In addition, providers are willing to consider alternative methods for treatment provided by the client. Clients have the right to request information regarding the training and credentials of the providers at this agency. If a client is to decide that this agency is not the right fit, that client may request a referral to another agency without mistreatment and with the full cooperation of the provider. The client is free to leave services at any time, although it is our recommendation that providers are given advanced notice for greater success in treatment conclusion and after-care.

COMPLAINTS / GRIEVANCES

It is the policy of Wolf Pack Consulting and Therapeutic Services, LLC. to have an open, prompt and responsive system in place for clients to enter a complaint, free from intimidation or retaliation. If you have a concern or complaint about services provided by this agency, we will make reasonable efforts to come to a resolution that is agreeable to all parties involved. You may contact any provider at Wolf Pack Consulting and Therapeutic Services, LLC to request an official grievance form. All grievances will be addressed by the Privacy Officer, Molly Griffith, BS, QMHA at 12655 SW Center Street Suite 100 Beaverton, OR 97005, 503.828.3402 (phone), 503.828.3401 (fax).

YOUR RESPONSIBILITIES

I agree to promote safety and well-being while receiving services with Wolf Pack Consulting and Therapeutic Services, LLC and will treat others with respect. Furthermore, while on Wolf Pack Consulting and Therapeutic Services, LLC property:

- I will not carry firearms or other weapons
- I will not use physical violence, threaten or insult others, or display threatening or insulting behavior
- I will not display inappropriate sexual behavior or gestures
- I will not use or possess alcoholic beverages or other mood-altering substances, including inhalants or toxic vapors
- I will not use tobacco products, including vape devices, on or within 10 feet of the Wolf Pack Consulting and Therapeutic Services, LLC property.

I further understand that I am to be actively involved in my treatment and I agree to comply with the rules and expectations set forth by Wolf Pack Consulting and Therapeutic Services, LLC.

I willingly give my informed consent to receive services from Wolf Pack Consulting and Therapeutic Services, LLC for six months from this date, or until the end of treatment, whichever comes last.

InformedConsent_WPCTS
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Wolf Pack
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Waiver of Liability

I release Wolf Pack Consulting and Therapeutic Services, LLC, its agents, employees, and contractors, of any and all responsibility and liability which may result from:

- An accident or incident which may cause injury to my person or to any and all child(ren) enrolled in treatment with me at Wolf Pack
- Any and all responsibility in case property belonging to me is left behind on Wolf Pack premises or damaged

I understand that Wolf Pack Consulting and Therapeutic Services, LLC, its agents, employees, and contractors:

- Are here to help me and any and all child(ren) enrolled in treatment with me to achieve wellness
- There is no guarantee of any particular outcome with treatment.
- The therapeutic process can be challenging and uncomfortable at times
- I agree to discuss this with the therapeutic professionals I and/or my family is working with or to discuss this with the clinical director should it at any time begin to feel too challenging to work through

This agreement shall remain valid until I am discharged from treatment with Wolf Pack Consulting and Therapeutic Services, LLC.

Waiver_WPCTS
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Client Bill of Rights

As a person receiving mental health services, you have the right to:

- Be treated with dignity and respect.
- Choose from available services and supports that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community, under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence.
- Ask questions and receive transparent answers about services.
- Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan.
- Request changes in treatment or service.
- Make a declaration for mental health treatment when legally an adult.
- Have access to peer delivered services.
- Receive treatment in the least restrictive setting – one that provides the most freedom appropriate to your treatment needs.
- Be informed about the rules that will result in discharge from a program if violated.
- Be informed of the policies and procedures, service agreements, and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented.
- Participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge, unless your behavior threatens the well-being of another person.
- Have all services explained, including expected outcomes and possible risks.
- Have your family or guardian involved in your treatment or refuse family participation in your treatment, as you choose.
- Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to service in the following circumstances:
    - Under age 18 and is lawfully married
    - Age 16 or older and legally emancipated by a court
    - Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.
- Not be subjected to verbal, physical, sexual, emotional, or financial abuse, harsh or unfair treatment.
- Refuse participation in experimentation.
- Receive medication specific to the your diagnosed clinical needs, including medications used to treat opioid dependence.
- Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety.
- Be free from seclusion and restraint.
- Be informed at the start of services and periodically thereafter of your rights guaranteed.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatment as a result of making a complaint.

- File a grievance if you are not satisfied with the response to a complaint, including appealing decisions that resulted from the grievance.
- Be assisted by an advocate of your choice; for example, family, friend, case manager, member of a consumer advocacy committee, or organization, etc.
- Inspect your service record in accordance with ORS 179.505.
- Be provided confidentiality in accordance with and decide those who are able to see your records in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50. Exceptions to this right include:
    - Providers involved in your mental health treatment
    - Providers of emergency medical care
    - An attorney representing you at a commitment hearing
    - A court
    - Those conducting a program or utilization review
    - Third party payers (those paying for your treatment)

  These parties may only see as much information as is needed for the specific purpose requested
- Not be discriminated against on the basis of race, ethnicity, age, gender, religion, spiritual orientation, national origin, citizenship status, sexual orientation, disability, veteran status, or marital status.
- Be free from abuse or neglect and report any incident of abuse or neglect without being subject to retaliation.
- Be provided with culturally relevant standards of practice that are conducted with culturally sensitive behavior.
- Exercise all rights described in this rule without any form of reprisal or punishment.
- Exercise all rights set forth in ORS 109.610 through 109.697 if the individual client is a child, as defined by these rules.
- Exercise all rights set forth in ORS 426.385 if you are committed to the Authority.
- Receive information about your rights in an alternative fashion, or have it discussed and explained to in a manner appropriate to your needs.

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Financial Agreement

Wolf Pack Consulting and Therapeutic Services accepts a variety of payment methods. Clinicians, intake coordinators, and billing staff will make their best efforts to obtain service reimbursement through the client's insurance provider, if available. If insurance is unavailable, and services are cost prohibitive, Wolf Pack Consulting and Therapeutic Services offers the options of a sliding fee scale (based on federal poverty guidelines) and / or payment plan. Fees for services are required, or will be billed for, at the time that the services are rendered, unless other arrangements / agreements have been made.

Agreement to obtain reimbursement from Insurance provider:

- I agree that I am responsible for providing Wolf Pack Consulting and Therapeutic Services, LLC with all the information necessary to bill my insurance company, including producing a copy of my insurance card when requested.
- I agree that I am responsible for any co-payment, deductible amount, or remaining balance incurred on behalf of myself and / or my minor child that is denied in whole or part by my insurance company.
- I am responsible for notifying my clinician or the billing coordinator at Wolf Pack Consulting and Therapeutic Services, LLC of any change in my insurance company or coverage prior to my next appointment.
- I authorize Wolf Pack Consulting and Therapeutic Services to share information with a third party (i.e. an insurance company) for the purpose of processing requests for service fee reimbursement.

Sliding Fee / Payment Plan:

Wolf Pack Consulting and Therapeutic Services is committed to ensuring that services are accessible to all. If obtaining services creates financial stress due to being uninsured or underinsured, please speak with your clinician, intake coordinator, or billing personnel. All recommended and / or requested services will be thoroughly explained and service fees would be reviewed and agreed upon prior to any charges.

Wolf Pack Consulting and Therapeutic Services uses the Federal Guidelines listed on the back of this form to establish fee agreements.

Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Nominal Fee ($5)	20% pay	40% fee	60% pay	80% pay	100% pay
1	0 - $13,590	$13,591 - $16,989	$16,990 - $20,385	$20,386 - $23,783	$23,784 - $27,180	$27,181+
2	0 - $18,310	$18,311 - $22,888	$22,889 - $27,465	$27,466 - $32,043	$32,043 - $36,620	$36,621+
3	0 - $23,030	$23,031 - $28,788	$28,789 - $34,545	$34,546 - $40,303	$40,304 - $46,060	$46,061+
4	0 - $27,750	$27,751 - $34,688	$34,689 - $41,625	$41,626 - $48,563	$48,564 - $55,500	$55,501+
5	0 - $32,470	$32,471 - $40,588	$40,589 - $48,705	$48,706 - $56,823	$56,824 - $64,940	$64,941+
6	0 - $37,190	$37,191 - $46,488	$46,489 - $55,785	$55,786 - $65,083	$65,084 - $74,380	$74,381+
7	0 - $41,910	$41,911 - $52,388	$52,389 - $62,865	$62,866 - $73,343	$73,344 - $83,820	$83,821+
8	0 - $46,630	$46,630 - $58,288	$58,289 - $69,945	$69,946 - $81,603	$81,604 - $93,260	$93,261+
For each additional person add	$4,540	$5,675	$6,810	$7,945	$9,080	$9,080

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Wolf Pack
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Service User & Community Complaint / Grievance Process

Policy Number: 1.8

Date last reviewed/revised: 05.18.2022

Approved by: Terry Ellis, LCSW

PREAMBLE

Wolf Pack Consulting and Therapeutic Services values and encourages the feedback of service users and community members regarding the programs and practices of the organization. Complaints can provide important opportunities and insights for improving service. A complaint may be defined as an expression of dissatisfaction or unmet expectation. A complaint can be made by the service user or community member with support if necessary. The complaint can relate to any aspect of the organization's programs and services.

POLICY

Wolf Pack Consulting and Therapeutic Services is committed to listening to service user and community member complaints and grievances and responding in a fair, timely, and respectful manner. All complaints will be given due consideration without reprisal or discrimination. Language support for non-English speaking service users or community members will be provided.

Wolf Pack Consulting and Therapeutic Services actively informs service users and community members of their right to register complaints or grievances (verbal or written) and seek resolution. This information is accessible and publicized in Wolf Pack Consulting and Therapeutic Services, Privacy Practices. Service users or community members who speak languages other than those covered by the latter documents or who have reading difficulties are encouraged to have this policy explained to them by a Wolf Pack Consulting and Therapeutic Services staff person at the beginning of services. Wolf Pack Consulting and Therapeutic Services will assist all persons to register their complaints and seek resolution. All complaints, grievances and appeal procedures will be handled in accordance with OAR **309-019-0215.**

All aspects of a complaint will be handled in confidence. However, if the complaint involves allegations of illegal or unethical behavior, information may need to be shared with external authorities.

All complaints are documented. The maintenance of complaint files is the responsibility of the privacy officer

SCOPE

The *Service User and Community Member Complaint and Grievance* policy applies to all Wolf Pack Consulting and Therapeutic Services programs and services.

PROCEDURES

1. Notification

1.1 Each individual or guardian obtaining services through Wolf Pack Consulting and Therapeutic Services shall receive, and be afforded the opportunity to review, a written copy of the policy upon entry.
1.2 This policy will also be available to services users or community members upon request.
1.3 Each individual or guardian obtaining services through Wolf Pack Consulting and Therapeutic Services shall receive a Service User / Community Complaint or Grievance Form upon , and anytime thereafter as requested.
1.4 An updated Grievance Process Notice will remain posted in common areas at all times.
1.5 Contact information for Coordinator Care Plans, The Division, Disability Rights Oregon, and The Governor's Advocacy Office will be provided upon request to any individual or guardian obtaining services.

2. Grievance filings and Response

2.1 The person receiving the complaint from the service user or community member should be offered the earliest opportunity to discuss their concern.
2.1 All complaints and grievances will be forwarded to and processed by Privacy Officer, Molly Griffith MollyG@wolfpackcts.org, 503.828.3402 (phone).
2.2 Resolution of grievance will be encouraged and completed at the lowest possible level.
2.3 All individuals, parents, and guardians will be provided assistance in understanding and completing the grievance process.
2.4 Any individual, parent, and guardian receiving services may file a grievance with the provider, the individual's coordinated care plan, or the Division.
2.5 Grievance investigations will be completed within thirty calendar days.

3. Documentation

3.1 All complaints or grievances will be documented using the *Service User / Community Complaint or Grievance Form*.
3.2 All complaints or grievances will be documented upon receipt, including all investigation steps as well as action taken in response.
3.3 Any action taken as the result of a substantiated grievance will be documented within three business days.
3.4 The grievance file (including all documentation, correspondence, resolution and follow up) is maintained separately from the service user's client record or the community member's file and is maintained by the Privacy Officer.
3.5 A record of the complaint will be made available to the complaint filer on request, except in the case where the confidentiality of another service user or community member may be breached.
3.6 These records will be retained for the same period of time as the client or community member record.

4. Review & Expedited Review

4.1 From the point a manager takes a call from a service user or community member, or calls a complaint filer about a complaint, a meeting between the manager and complainant should be offered within five working days.
4.2 A letter must be sent to the service user or community member within two weeks of meeting. The Director is informed of the complaint and the resolution or lack of resolution thereof.
4.3 In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures are completed, the individual or guardian of the individual may request an expedited review within 48 hours of receipt of the grievance. The written response shall include information about the appeal process.

5. Non-Retaliation

5.1 A grievant, witness, or staff member of a provider may not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include but is not limited to, dismissal or harassment, reduction in services, wages, or benefits, or basing service or a performance review on the action.
5.2 The grievant is immune from any civil or criminal liability with respect to the making of, or content of, a grievance made in good faith.

6. Appeals

6.1 Individuals and their legal guardians may appeal entry, transfer, and grievance decisions as follows:

a) If the individual or guardian is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial of services. The appeal shall be submitted to the Division;
b) If requested, program staff shall be available to assist the individual;
c) The Division shall provide a written response within ten working days of the receipt of the appeal;
d) If the individual or guardian is not satisfied with the appeal decision, they may file a second appeal in writing within ten working day of the date of written response to the Division Director.

6.2 If the service user or community member is not satisfied with the response from the manager they will be informed of the name and phone number of the Director if they wish to pursue the complaint.
6.3 If requested, the Director will meet with the service user or community member within two weeks of receiving the request.
6.4 The Director will attempt to resolve the problem with the service user or community member. Whatever the outcome, the Director will inform the complaint filer by mail not more than two weeks after the meeting.

GrievancePolicy_WPCTS
Created: 05.23.2017
Revision: 05.18.2022

Wolf Pack
Consulting and Therapeutic Services, LLC
(p) 503.828.3338
(f) 503.828.3401
contact@wolfpackcts.org

Service User / Community Complaint or Grievance Form

Service User or Community Member Information

Name:
Phone:
Email and/or Postal Address:

Complaint Information

Date:
Complaint / Grievance:
Solutions Sought by Service User or Community Member: (note the solutions the complaint filer is seeking to each of the issues listed above)
Complaint / Grievance Background: (brief description of client's circumstances and situation leading to complaint)

Actions Taken

Step 1:
Date:
Staff Involved:
Notes:
Next Steps:
Step 2:
Date:
Staff Involved:
Notes:
Next Steps:
Step 3:
Date:
Staff Involved:
Notes:
Next Steps:
Step 4:
Date:
Staff Involved:
Notes:

Next Steps:

Outcome Resolution

(describe outcome of complaint and any improvements implemented as a result)

Name of Staff Member Signature

Name of Manager Signature

Name of Director Signature

_____

Date

GrievanceForm_WPCTS
Created: 06.11.2017
Revision: 05.18.2022

Wolf Pack
Consulting and Therapeutic Services, LLC
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contact@wolfpackcts.org

Consent to Treatment and Form Acknowledgment

I acknowledge that I have read, understood and I agree to the following forms. I may be provided a copy of these upon my request:

_____ Privacy Practices
_____ Informed Consent
_____ Liability Waiver
_____ Client Bill of Rights
_____ Financial Agreement
_____ Grievance and Appeals Form
_____ Declaration of Mental Health (Adults, 18 years and over)
_____ Voter Registration (Adults, 18 years and over)

- I have chosen to receive mental health related services from Wolf Pack Consulting and Therapeutic Services, LLC. My decision is voluntary and I understand that I may terminate these services at any time.
- I understand that during the course of my work with those employed and contracted by Wolf Pack Consulting and Therapeutic Services, LLC, I may at times discuss material of an upsetting nature.
- I also understand that it cannot be guaranteed that I will feel better after completion of treatment.
- I agree to participate in the development of an individualized treatment plan. I understand that my attendance and active participation is essential to the success of my treatment.
- I understand there are certain circumstances which may require Wolf Pack Consulting and Therapeutic Services, LLC providers to receive supervision. These circumstances include, but are not limited to the following:
    - State licensure regulations may require my therapist or service provider to receive ongoing supervision
    - Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
    - The standards of care which guide most mental health professionals recommend that supervision and / or consultation be obtained in high risk situations such as threats and / or acts of harm to self or others.
    - Other special circumstances, such as preparation if subpoenaed to testify in court.
- I understand that if I am unable to reach my provider at Wolf Pack Consulting and Therapeutic Services, LLC my call will be returned as soon as possible.
- If I have a life-threatening emergency situation, I will call 911.

I acknowledge that I have read, discussed, and understood all of the above

Name of Client (please print): _____

_____ _____

Client Signature (14 years and older) Date

_____ _____

Parent/Guardian Signature & Relationship Date

_____ _____

Provider and Credentials Date

16365 NW Twin Oaks Drive Suite 200 Beaverton OR 97006
Mailing: 16055 SW Walker Road #443 Beaverton OR 97006
www.wolfpackcts.org

Wolf Pack
Consulting and Therapeutic Services, LLC
(p) 503.828.3402
(f) 503.828.3401
contact@wolfpackcts.org

Authorization to Use/Disclose Health Information

Legal Name:	Preferred Name:	Date of birth:

I hereby authorize: Wolf Pack Consulting and Therapeutic Services, LLC
16365 NW Twin Oaks Drive Suite 200 Beaverton, OR 97006
All mail to: 16055 SW Walker Road #443 Beaverton, OR 97006
503.828.3402 (office), 503.828.3401 (fax)

To release information to ☐ and/or

To receive information from ☐

Person:	Organization:
Address:	
Phone Number:	Fax Number:
Email Address:	

I specifically authorize the release/exchange/receipt of the following information:

Mental Health Records Including:

(*Indicate by initialing*)

____ Identifying Information

____ Lab Records

____ Medical Records & X-rays

____ Mental Health Treatment Records

____ Psychiatric Evaluation(s)

____ Progress Notes

____ Discharge/Transfer Summary

____ Other (*specify*): _____

Substance Use Disorder Records:

(*Indicate by initialing*)

____ Identifying Information

____ Lab Records/Urinalysis

____ Medical Records & X-rays

____ Substance Use Treatment Records

____ Psychiatric Evaluation(s)

____ Progress Notes

____ Discharge/Transfer Summary

____ Other (*specify*): _____

I recognize that the information released may contain information regarding **mental health** treatment that is protected by state law (ORS 179.505 & 192.505, 45 CFR 205.50). I specifically consent to its release.

Signature: _____

Date: _____

I recognize that the information released may contain **drug/alcohol** information that is protected by federal and state law. [42CFR2.31, ORS 430.399(5) & 179.505]. I specifically consent to its release.

Signature: _____

Date: _____

Purpose of such disclosure: ***(Choose all that apply)***

- ☐ Treatment Planning
- ☐ Referral/Consultation
- ☐ Legal Issues
- ☐ Facilitate Health Benefit Utilization
- ☐ Diagnosis and Evaluation
- ☐ Coordinate Aftercare/Ongoing Treatment/Services
- ☐ Coordination of Care
- ☐ Other (*specify*): _____

The individual signing this form agrees and acknowledges the following:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(ii) **Effective Time Period:** This authorization shall be in effect for one year after it is signed unless a specified termination date it requested: **Month:** _____ **Day:** _____ **Year:** _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

SIGNATURES:

Client/Legal representative: _____ Date:_____

If Legal representative, relationship to client: _____

ROI_WPCTS
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Wolf Pack
Consulting and Therapeutic Services, LLC
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Custody, Guardianship, & Rights to Information Access for Minors

Date:

Client:
Date of Birth:

Birth Parent 1: Date of Birth:
☐ Has Custodial Rights ☐ Can have contact ☐ Rights to Records/Information

Birth Parent 2: Date of Birth:
☐ Has Custodial Rights ☐ Can have contact ☐ Rights to Records/Information

☐ There is a shared custody situation where _____ and _____ both share custodial rights equally.

Legal Guardian (if different):
Guardianship/custody established date:
☐ Has Custodial Rights ☐ Can have contact ☐ Rights to Records/Information

Caregiver (if different):
Began providing care date:
☐ Has Custodial Rights ☐ Can have contact ☐ Rights to Records/Information

☐ Yes, there is, ☐ No there is NOT a current court order establishing custody, information rights, etc.

If YES, court order was established on _____ (date) in _____ (county), _____ (state).
If YES, is a copy of this order attached? ☐ Yes ☐ No

Are there any no contact orders or restraining orders pertaining to client ☐ Yes ☐ No
If Yes, please describe:
If YES, is a copy of this order attached? ☐ Yes ☐ No

Other extenuating legal circumstances around minor child not described above:

I attest that the above information is accurate and complete

_____ _____

Legal Guardian Signature Date

_____

Printed Name & Relationship

_____ _____

Provider Received By Date

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Mailing: 16055 SW Walker Road #443 Beaverton OR 97006
www.wolfpackcts.org

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Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Name_____ Today's date_____
Preferred Pronoun_____ Date of Birth_____
Primary Care Provider: _____ Clinic or Office: _____
Last Seen: _____(month) / _____ (year)

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Anemia	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Chronic diarrhea	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
If yes, what age?_____			Stroke	☐ Yes	☐ No
Emotional problems	☐ Yes	☐ No	Venereal disease/Syphilis	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Gonorrhea/Chlamydia	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers (stomach or intestinal)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Acid Reflux (Heartburn)	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Other Autoimmune or immunosuppressive condition	☐ Yes	☐ No

If yes to any of the above, please explain:_____
_____
_____
_____

When was your last Tetanus shot given? _____

(more on next page)

2. Family Medical History

☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

			Family Relationship:	Living/Deceased:
Alcoholism	☐ Yes	☐ No		
Anemia	☐ Yes	☐ No		
Arthritis	☐ Yes	☐ No		
Bowel/Colon Cancer	☐ Yes	☐ No		
Breast Cancer	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Heart Disease/Angina	☐ Yes	☐ No		
Hepatitis	☐ Yes	☐ No		
High Blood Pressure	☐ Yes	☐ No		
High Cholesterol	☐ Yes	☐ No		
Kidney Disease	☐ Yes	☐ No		
Strokes	☐ Yes	☐ No		
Thyroid Disorder	☐ Yes	☐ No		
Tuberculosis	☐ Yes	☐ No		
Mental Illness	☐ Yes	☐ No		
Other_____	☐ Yes	☐ No		

3. Personal Habits & Risk Factors

Tobacco Use

Cigarettes: ☐ Never ☐ Quit-Date_____ ☐ Current Smoker-Packs per day__# of years_____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

If yes, average # of drinks per week____

If no, have you in the past? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills? ☐ Yes ☐ No

Have you ever used needles? ☐ Yes ☐ No

Sexuality

Are you sexually active? ☐ Yes ☐ No ☐ Not currently

Do you use protection:

Condoms?	☐ Sometimes	☐ Always	☐ Never
PrEP?	☐ Sometimes	☐ Always	☐ Never
Birth Control?	☐ Sometimes	☐ Always	☐ Never

Other _____

Have you ever had any sexually transmitted diseases (STD's)? ☐ Yes ☐ No

If yes, please include_____

When were you last tested? _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercises?_____

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? ☐ Yes ☐ No

4. TB Risk Assessment

Were you born in or have you lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean, or the Middle East for more than one month?	☐ Yes ☐ No
In the last 2 years, have you lived or spent time with someone who has been sick with TB?	☐ Yes ☐ No
Have members of your household come to the United States from another country?	☐ Yes ☐ No
If yes, name of country: _____	
Have you ever been to jail or prison?	☐ Yes ☐ No
Have you ever had an organ transplant?	☐ Yes ☐ No
Have you ever worked anywhere that processed TB samples?	☐ Yes ☐ No
Have you ever been told you have an abnormal chest X-Ray?	☐ Yes ☐ No
Have you had any symptoms of TB (couch, fever, night sweats, loss of appetite, weight loss, or fatige)?	☐ Yes ☐ No
If yes, name symptom and when: _____	
Have you been homeless (Including living in a shelter) in the last 30 days?	☐ Yes ☐ No
Do you perform work that involves sexual contact?	☐ Yes ☐ No
Have you been sexually assaulted in the last 30 days?	☐ Yes ☐ No
Have you had a needle stick injury since you were last tested for any infectious disease?	☐ Yes ☐ No

5. Medications

Please list all your current medications, including medications/supplements not needing a prescription:

Medication	Dose and Directions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(more on next page)

6. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect

7. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation

8. If Applicable

Total # of pregnancies _____ # of deliveries _____ # of miscarriages _____ # of abortions_____

Age at start of menstrual period _____

Date most recent menstruation began _____ Usual length of menstrual period _____days

Date of last Pap smear _____

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, give date and describe_____

Have you stopped having menstrual periods? ☐ Yes ☐ No If yes, when_____

Are you or have you experienced menopause? ☐ Yes ☐ No

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods	☐ Yes	☐ No
Bleeding between periods or after menopause	☐ Yes	☐ No
Vaginal discharge, pain or itching	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No
Pain or lumps in breasts	☐ Yes	☐ No

(Next page for providers only)

For Providers only:

Need for Medical Follow up:
As a result of reports of sudden unexplainable behavior change, rapid or major weight loss or gain, reports of compulsive behavior or addiction history, acute signs or symptoms of substance withdrawal, or reports of injected intravenous drugs currently or within the last 3-6 months), client has been referred to:

☐ Primary Care Provider
☐ Onsite medical provider
☐ Medical Director waived referral for physical examination and lab testing due to documentation that client has received these services in the past 90 days

Pregnancy Risk
☐ Referral made for testing
☐ Referral made for prenatal care (within 14 days)

Withdrawal from Substance Use
☐ Symptoms of withdrawal resulted in staff consulting with onsite medical provider within 24 hours

Infectious Disease
☐ Client's identified at risk for infectious disease
If checked, then…
☐ Client has been referred to onsite medical provider for further examination, risk assessment, lab testing.
☐ Client has been referred to other care provider: _____

As a result of any of the following in the last 30 days:

- Intravenous drug use
- Homelessness / Living on the street / Living in a shelter
- Release from Jail or Prison
- Coming into contact with another person's blood
- Needle stick injury
- Sexual assault
- High risk sexual behavior
- Work that involves sexual contact

MedicalHistory_WPCTS
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