Wyoming Behavioral Institute

2521 EAST FIFTEENTH STREET
CASPER, WYOMING 82609
307-237-7444

PATIENT NAME: _____ TIME: _____ DATE: _____

1. ACKNOWLEDGEMENT OF ADMISSION	**PATIENT/GUARDIAN INITIALS**

MEDICAL/PSYCHIATRIC/CHEMICAL DEPENDENCY TREATMENT CONSENT: The patient care is under the direction of his /her attending physician(s), and the hospital is not liable for any act or omission in following the instructions of said physician(s), and the undersigned consents to any radiology examination, laboratory procedures, medical/psychiatric/chemical dependency treatment of hospital services rendered to the patient under the general and special instructions of the physician. I, undersigned, recognize that all doctors of medicine providing services to the patient, including radiologist and other professionals, may be independent contractors and not employees or agents of the hospital. ***I AM AWARE SOME OF THE SERVICES MAY BE RENDERED FROM CONSULTATIVE FACILITIES AND/OR PERSONNEL AND THAT I MAY BE RESPONSIBLE FOR PAYMENT TO THESE CONSULTANTS.*** The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, as to the results of any services provide to the patient, including, but not limited to therapy, treatment, tests or procedures, while admitted at WBI. The undersigned further acknowledges that the care, treatment, and services provided by Wyoming Behavioral Institute do not guarantee the prevention of future detrimental behavior/actions. ***I AM AWARE THAT A PHYSICIAN IS NOT STAFFED IN THE PREMISES 24 HOURS A DAY, BUT A PHYSICIAN IS ON-CALL AND MAY BE REACHED 24 HOURS A DAY BY HOSPITAL STAFF.***

I AM AWARE THAT SOME OF PROFESSIONAL SERVICES MAYBE PROVIDED VIA TELE-PSYCH OR INTERNET BASE INTERACTIONS. THESE PROVIDERS ARE CREDENTIALED BY WBI.

2. ACKNOWLEDGEMENT FOR EMERGENCY TREATMENT	**PATIENT/GUARDIAN INITIALS**

In case of an emergency, I give my consent to be transported to, if possible, the nearest hospital of my choice, for evaluation and treatment by the attending physician on duty.

3. RECORDS RELEASE FOR INSURANCE:	**PATIENT/GUARDIAN INITIALS**

I hereby authorize the hospital to disclose medical/psychiatric/chemical dependency treatment information, which may include alcohol/drug abuse and mental health records obtained in the course of my diagnosis and treatment, to any person or corporation which is or may be liable under contract to the hospital, for all or part of the hospital's charges, including hospital or medical service companies, insurance companies, worker's compensation carriers and/or Medicare/Medicaid funds. This consent is subject to revocation by me at any time (in writing), except to the extent action has been taken in reliance thereon, and unless earlier revoked, shall expire upon final payment in full of the hospital's charges related to this admission.

4. EXPLANATION OF CHARGES:	**PATIENT/GUARDIAN INITIALS**

The estimated amount quoted for hospitalization is for HOSPITAL CHARGES ONLY. The benefits quoted by your insurance carrier and relayed to the Business Office is only an ESTIMATE and NOT a guarantee of payment and it is not intended to be a final statement of financial responsibility. It is our recommendation that you check with your insurance company or your policy to determine and understand your coverage. Although we will pre-certify your admission, the primary responsibility is YOURS.

All insurance plans are private contracts between individuals and their insurance company. As a courtesy, we will bill your insurance company for you. If we have not received payment from your insurance company within 45 days after they have received the claim, you will be responsible for the charges and a payment arrangement will need to be made. I authorize and consent to a credit inquiry on me being made by the Hospital. I further understand that any charges not paid by the insurance must be paid by me. *Hospital Business Office hours are: 0800 to 1700 (5pm) Monday thru Friday.*

PATIENT ADDRESSOGRAPH LABEL

5. PROPERTY DAMAGE:	PATIENT/GUARDIAN INITIALS

Any damage to the hospital property caused by myself or the patient I am signing for will be billed to my account for the cost of repairs or replacement.

6. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:	PATIENT/GUARDIAN INITIALS

I, the undersigned agree, whether signing as agent or patient, that in consideration of the admission of the patient in this hospital, and for services to be rendered to the patient, I hereby authorize payment directly to WYOMING BEHAVIORAL INSITUTE AND THE ABOVE-NAMED PHYSICIAN(S) of the hospital/physician(s) benefits and/or major medical benefits otherwise payable to me for the hospitalization of the patient. I understand that I am financially responsible to the hospital and physician(s) for all charges not covered by this assignment, and hereby assume full responsibility for the payments. Should the account be referred to an outside collection agency or attorney for collection, I shall pay reasonable attorney's fees, interest, and collection expenses allowable by law.

PHYSICIAN & PROFESSIONAL SERVICES BILLING: Please be aware the certain professional services rendered during your stay may be provided by physicians and mental health professionals who are independent providers and are not employees or agents of the hospital. These fees will be billed to you directly by the physician or provider who performs the services. **Our physicians, in general, are an independent provider. You will be receiving a separate billing from his/her office.**

7. PATIENT CONFIDENTIALITY	PATIENT/GUARDIAN INITIALS

I understand that my information and my medical record will be kept in the utmost confidential manner. Information will be released only with my written authorization or under the Tarasoff Case rules of "duty to warn". This requires healthcare professionals to warn person(s) of threats by a patient. "Privacy ends when peril to the public begins."

I understand that my behavioral health treatment records (including drug and alcohol) and information are protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2, and the HIPAA Privacy Rule, 45CRF, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations. This has been explained to me and I have been allowed to ask questions.

7a. MINOR PATIENTS	PATIENT/GUARDIAN INITIALS

To provide the best therapeutic setting for my child. I, the undersigned, agree to allow therapeutic content to remain confidential between my child and the treatment team. I understand that I may ask for and receive explanations of treatment process/progress.

I am also aware that under Wyoming Statute 20-2-113 (f), a non-custodial parent has the same right to access to healthcare records as the custodial parent/guardian unless otherwise ordered by the court.

I understand that I have been asked to provide a copy of custody papers for my child. I understand that without these custody papers, WBI may not be able to restrict access and/or information to the non-custodial parent.

If the records are regarding someone under the age of 18 who has had drug and/or alcohol diagnosis, treatment or education, Federal Regulations require us to obtain the signature of the minor too. Per Wyoming Statutes, a non-custodial parent has the same right to information on a minor as a custodial parent.

8. CHURCH SERVICE ATTENDANCE.

The undersigned understands and give permission for my child to attend Bible studies and church services if he/she desires while hospitalized at Wyoming Behavioral Institute. Further information about these services are included in the patient handout.

Parent/Guardian Signature:_____

9. PERSONAL VALUABLES	PATIENT/GUARDIAN INITIALS

I understand that the hospital maintains a safe for the safekeeping of money and valuables of small size. The hospital shall not be liable for the loss or damage of any money or personal property. *WE STRONGLY RECOMMEND THAT ANY BELONGINGS OF MONETARY VALUE OR SENTIMENTAL VALUE BE SENT HOME, AS WYOMING BEHAVIORAL INSTITUTE* ***WILL NOT BE RESPONSIBLE FOR THE LOSS OF THESE ITEMS.***

10. CONSENT TO SEARCH:	PATIENT/GUARDIAN INITIALS

To ensure my safety and the safety of all other patients and staff, I understand upon admission a member of the hospital staff will search my clothing, belongings, and person. During hospitalization, random searches may occur if a question of safety arises. Any weapons brought into Wyoming Behavioral Institute will be confiscated and sent home with family/friends or will be turned over to Casper Police Department.

11. PHOTOGRAPHS:	PATIENT/GUARDIAN INITIALS

I acknowledge my photograph will be taken as means of identification and understand that these photographs will become part of my medical records. Camera monitoring is used throughout the facility for safety.

12. PATIENT RIGHTS	PATIENT/GUARDIAN INITIALS

The undersigned acknowledges that a copy of the patient rights has been given to them and that these rights have been explained, and that they understand these rights.

13. ADVANCE DIRECTIVES	PATIENT/GUARDIAN INITIALS

The undersigned acknowledges that he/she has been given written material about his/her right to accept or refuse medical and mental health treatments, been informed of his/her rights to formulate Advance Directives, understands that he/she is not required to have an Advance Directive in order to receive medical and mental health treatment at this health care facility, and further understands that if he/she has executed Advance Directives (and have given WBI a legible copy of it) it will be followed by the health care facility and my caregivers to the extent permitted by law.

A "**Do Not Resuscitate Advanced Directive**" **cannot be honored at WBI.** If the patient experiences cardiac or respiratory arrest they will be resuscitated in the most aggressive and comprehensive manner available and will be immediately transferred to an acute care hospital for further intervention. In the event a patient is transferred to another hospital, any Advance Directive contained in the medical record shall be forwarded to such hospital."

I HAVE an advance directive. ☐ Yes ☐ No If yes, WBI has requested a copy ☐ Yes ☐ No

_____ I HAVE been given written material _____ Patient refused written material
_____ the patient is a MINOR (no information needed)

14. PSYCHIATRIC ADVANCE DIRECTIVES	PATIENT/GUARDIAN INITIALS

Initials above ↗ indicates receipt of additional information describing the philosophy of the use of psychiatric interventions.

The undersigned understands that the use of reasonable interventions (may include i.e. restraints, seclusions, protective holds, medications) may be used for management of behavioral psychiatric emergencies if the symptoms or behaviors warrant, in order to protect the patient from harming him/herself or others. The undersigned agrees to the notification of the individual listed below to receive notification in the event of a psychiatric emergency. ____yes ____no
*If yes, please call Name/relationship*_____*(required for adult)*

*Phone:*_____ *Alt phone:*_____

Further information about interventions and philosophy of seclusion & restraints are located in the patient handout.

PATIENT ADDRESSOGRAPH LABEL

15. PROFESSIONAL STUDENTS	PATIENT/GUARDIAN INITIALS

The undersigned understands that Wyoming Behavioral Institute has entered into agreements with severe institutions of teaching to provide student with exposure and limited experience in the mental health and/or behavioral health field. Following are types of student recognized by Wyoming Behavioral Institute.

NURSES	PSYCHOLOGIST CANDIDATES	MEDICAL STUDENTS
OCCUPATIONAL THERAPISTS	PHYSICIAN ASSISTANTS (PA)	MASTER LEVEL CANDIDATES
BSW'S	RESIDENT PHYSICIANS	FINANCIAL PRACTICES

☐ FORMAL VOLUNTARY ADMISSION

I, the undersigned, hereby request admission to Wyoming Behavioral Institute and agree to abide by the rules and regulations of the facility. I have been informed that if I desire to be discharged, ***I shall provide twenty-four (24) hours written notice*** to the Wyoming Behavioral Institute. (W.S. 10-108)

PATIENT/GUARDIAN INITIALS

☐ INVOLUNTARY ADMISSION

The undersigned was informed that under WYOMING STATUTE 25-10-112 section *"(d) The hospital or other treatment provider shall attempt to recover all costs of treatment from public and private health insurance, from patients, and from government benefit programs prior to seeking payment from the county or the department."*

☐ Patient refused to sign
☐ Patient was unable to sign due to:_____

PATIENT/GUARDIAN INITIALS

Initials _____ I acknowledge that I have received the **Patient Handout** which also includes further information on:

- Church Service Attendance
- Code of Conduct
- Grievance & Complaint Process
- Patient guide to prevent medical errors
- Seclusion & restraints
- Financial Practices

I understand that it is my responsibility to read this information, understand and abide by it. The staff is available to answer questions that I may have.

_____ _____ _____
PATIENTS NAME (please print) PATIENTS SIGNATURE DATE

_____ _____ _____ _____
SIGNATURE OF LEGAL GUARDIAN (FOR MINOR OR INCOMPETENT PERSON) DATE SIGNATURE OF INSURED/GUARANTOR DATE

_____ _____
WYOMING BEHAVIORAL INSTITUTE STAFF DATE

PATIENT ADDRESSOGRAPH LABEL