serenity
treatment center house
central peninsula general hospital

(907) 714-4521 Intake Office
(907) 260-4063 Intake Office Fax

PATIENT RULES AND REGULATIONS

1. No phone contact privileges for your first week in treatment.
2. Telephone time is from 5:30 p.m. until 10:00 PM daily, unless it's a treatment task, but may not interfere with regularly scheduled groups and/or activities. Please restrict your calls to 10 minutes. We will only accept emergency incoming calls.
3. There are no pass privileges for the first two weeks in treatment. Passes may be issued Saturdays for 4 hours. Pass can be submitted to treatment team on Tuesday prior to pass date for treatment team approval.
4. No smoking, vaping or chewing; Tobacco products prohibited on all CPH property
5. Male patients may not visit in a female patient's room. Female patients may not visit in a male's room.
6. Patients must be fully and appropriately dressed when in common area including footwear.
7. No hats are to worn in the house.
8. Meals and treatment activities must be attended on time. Even if you do not eat, you need to spend 10 minutes at the table with your peers and participate in prayer.
9. Patients are responsible for cleaning their room and doing their own laundry during their free time, *not group time. Rooms will be inspected by team members, should a room not pass inspection the entire group will lose phone privileges from 3-5 days.*
10. A urinalysis test may be done when returning from passes and outside meetings. Compliance is mandatory. Non compliance will result in discharge immediately.
11. Lights out is 10:30 PM. everyone must retire to their room and shutoff lights.
12. No use of any mood-altering chemicals will be permitted while in treatment.
13. When at the gym, patients may not leave the premises for any reason, patients must work out. Patients may not use the phone or the tanning bed when at the gym.
14. Patients are not allowed to bring outside reading material including newspapers.
15. No CDs, tapes, headphones or unrelated treatment materials will be allowed on the premises. No television, radio, or cell phones. If patient plans to make long distance phone calls, bring a phone card or charge card.
16. No cussing or intimidation of counselors or peers.
17. Sexually harassing behavior will not be tolerated, this includes but is not limited to; touching, sexual innuendos, sexual humor, and stories of a sexual content.
18. Clothing must cover entire stomach, buttocks, and shoulders at all times. You will be asked to change if attire is deemed inappropriate by staff.
19. No food or beverages outside of the kitchen area, water is allowed in a covered sippy bottle. Absolutely NO CANDY, SNACK FOODS OR SODA'S IN BEDROOMS.

FAILURE TO COMPLY WITH RULES AND REGULATIONS MAY RESULT IN EARLY DISCHARGE

I have read and understand the above Rules and Regulations.

Patient's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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CLIENT BILL OF RIGHTS

Serenity House supports and protects the fundamental human, civil, constitutional, and statutory rights of each client.

Serenity House's treatment program has been designed with the intention of meeting the client's individual "needs" that may be conductive to their recovery. We view the client's individual needs as a priority of this program. The client has a voice in the modification of their treatment services. Client program evaluation forms and suggestion boxes are available. Completed evaluation forms may be given to a staff member.

A. **YOU HAVE THE RIGHT** to quality care and to treatment with dignity and respect as a person.

B. **YOU HAVE THE RIGHT** to reasonable expect to obtain from your counselor complete and current information about your evaluation, treatment, and recovery in terms and language that you can understand.

C. **YOU HAVE THE RIGHT** to know by name and responsibility, the staff member(s) involved in your treatment.

D. **YOU HAVE THE RIGHT** to consideration of your privacy and individuality as it relates to their physical, social, religious and psychological well-being within the constraints of the program setting.

E. **YOU HAVE THE RIGHT** to expect the Program staff to make reasonable response to your requests within the framework of the therapeutic policies of the treatment program.

F. **YOU HAVE THE RIGHT** to information about the relationship to other health care institutions and agencies so far as your care or referral are concerned.

G. **YOU HAVE THE RIGHT** to expect reasonable continuity of care in your treatment, which shall include, but not be limited to, the appointment times that staff is available.

H. **YOU HAVE THE RIGHT** to confidentiality as it relates to your treatment program. Case consultation and treatment issues may be reviewed within the staff and will be discussed discretely and confidentially.

I. **YOU HAVE THE RIGHT** to the confidentiality of your treatment record. Information from the treatment record can be released to other persons and agencies only when you complete a "Release of Confidentiality" form specifying the person or agency.

J. **YOU HAVE THE RIGHT**, when significant alternatives for your care and treatment exist, to information concerning alternatives, such information shall be provided without violating your confidentiality.

K. **YOU HAVE THE RIGHT** to discuss any non-disciplinary discharge planning.

L. **YOU HAVE THE RIGHT** to inspect the Program's Policy and Procedure Manual by requesting, in writing, and appointment with the counselor.

M. **YOU HAVE THE RIGHT** to refuse treatment to the extent permitted by law and to be informed of the consequences of their actions.

N. **YOU HAVE THE RIGHT** to examine and receive an explanation of your bill regardless of sources of the payment.

O. **YOU HAVE THE RIGHT** to express a grievance or a complaint that you may have relating to your treatment. Every effort will be made to resolve complaints with the person with whom they occur.

It is recognized that some grievances are unmanageable. If you have a grievance with the Program, the first step is to thoroughly discuss it with your counselor. If no resolution is obtainable, the second step is for you to put your grievance in writing to the supervisor with the request for a meeting appointment. If no resolution is forthcoming from this meeting with the supervisor, you may contact Central Peninsula Hospital's Administrator at (907) 714-4404. If resolution is still outstanding, you may contact the State of Alaska Division of Behavioral Health at (907) 269-3600.

CLIENT RESPONSIBILITIES

A. **YOU HAVE THE RESPONSIBILITY** to provide information about present complaints, past and current functioning, hospitalizations, medications, and other matters related to their behavioral and physical health.

B. **YOU HAVE THE RESPONSIBILITY** to share expectations of and satisfaction with the program.

C. **YOU HAVE THE RESPONSIBILITY** to ask questions when you do not understand your care, treatment, or services or what you are expected to do.

D. **YOU HAVE THE RESPONSIBILITY** to follow instructions for your plan of care, treatment, or services, and expressing concerns about your ability to follow the proposed plan of care, treatment, or services.

E. **YOU HAVE THE RESPONSIBILITY** to accept consequences for the outcomes of care, treatment, or services if you do not follow the planned care, treatment, or services.

F. **YOU HAVE THE RESPONSIBILITY** to follow the program's policies and procedures.

G. **YOU HAVE THE RESPONSIBILITY** to show respect and consideration of program's staff and property, as well as other individuals and their property.

H. **YOU HAVE THE RESPONSIBILITY** to meet financial commitments.

I. **YOU HAVE THE RESPONSIBILITY** to provide the program the signed written acknowledgement confirming that your responsibilities were explained.

_____ _____

Client Signature Staff Signature

_____

Date

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CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing; or,
2. The disclosure is allowed by a court order; or,
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or,
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate state or local authorities, (see 42 U.S.C., 290 EE-3, 290 FF-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.

I have read and understand <u>The Client Bill of Rights</u>.

_____	_____
Client Name	Client Signature
_____	_____
Witness	Date

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FINANCIAL POLICY

Thank you for choosing us as your treatment provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Services will be billed and submitted to insurances as appropriate. We will offer an extended payment plan if need is documented. All charges are your responsibility.

Insurance

We may accept assignment of insurance benefits at the time of your assessment or intake appointment. The balance is your responsibility whether the insurance company pays or not. We cannot bill your insurance company only if you give us your insurance information, a copy of your insurance card and/or an original claim form are requested when you are admitted.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our Utilization Review Team will comply with all necessary clinical reviews as required by your insurance company. If, however, your insurance company has not paid your account within 45 days, the balance will become your responsibility. Our agency is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please let us know if you have questions or concerns regarding our Financial Policy.

I have read, understand, and agree to this Financial Policy.

Client Name: _____ Client Number: _____

Client Signature: _____ Date: _____

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PROOF OF INCOME CHECKLIST

At this time, Serenity House Treatment Center accepts all major insurance, Medicaid and self pay clients.

If you require financial arrangements for your treatment payments, you will need to bring in proof of your family's gross income.

The following is a list of items that could help provide that proof:

1. If employed, bring in most current pay stub for yourself and spouse, if married.
2. Most recent W-2 or copy of last year's tax return.
3. If you are receiving any of the following, you must also bring proof in the form of your most recent pay stub:
    - Unemployment
    - Social security income
    - Retirement pension
    - Disability income
    - Public assistance
    - Native corporation dividends
    - Permanent fund dividend (proof of filing with batch card)

If you have no income, you must provide other documentation and inform your evaluator.

I have read, understand, and agree to the Proof of Income requirements.

Client's Signature _____ Date _____