CITIZEN POTAWATOMI NATION BEHAVIORAL HEALTH
2307 S. GORDON COOPER DR., SHAWNEE, OK 74801
PHONE 405-214-5101 FAX 405-878-5846

NEW PATIENT QUESTIONNAIRE - CHILD

This questionnaire is designed to improve your first visit with your new doctor. It is helpful because it allows your doctor to understand your needs better and allow your first visit to go more smoothly. All unnecessary items have been removed to ensure that your time is not wasted. Please fill the form out as completely as you can and bring supporting materials like medical records from a previous provider and/or any previous test results with you to your first appointment. If you can't bring them, please list your provider so we may contact them to obtain the necessary documents. If you aren't comfortable answering a question, leave it blank. Lastly, please be very brief, we will discuss things in more detail during your visit.

Last ______________________ First ____________________ MI _____ Date ______________

Maiden (if applicable) ___________________ SSN ___________________ DOB ______________

☐ Male ☐ Female ☐ Transgender ☐ Two-Spirit ☐ Intersexed ☐ Other ______________

Tribe(s) ____

Phone: Primary ________________ Secondary __________________ Work

May we leave a message? ☐ Yes ☐ No

Address ____ Apt __________

City ____ State _____ Zip _______________

Referred by ☐ Self ☐ PCP ☐ Other ____

Emergency Contact

Name ____ Relationship _________________

Address ____ Phone _________________

Next of Kin

Name ____ Relationship _________________

Address ____ Phone _________________

Biological Mother ____ Phone _________________

Address ____

Biological Father ____ Phone _________________

Address ____

Parents are: ☐ Married ☐ Divorced ☐ Committed Relationship ☐ Separated

If Divorced/Separated, custody arrangement ____

Do both parents retain their parental rights? ☐ Yes ☐ No

Please list all siblings and ages, include if full or half ______________________________

____

List all people living in the home ______________________________

____

List any step-parent or other committed partner ______________________________

If anyone other than parents will bring your child for treatment, please sign a "Minor Consent Form" provided at Registration.

Is your child currently in a relationship? ☐ Yes ☐ No
If yes, list name and age ______________________________
Duration of relationship __________ Currently sexually active? ☐ Yes ☐ No ☐ Unknown

Is your child currently employed? ☐ Yes ☐ No
If yes, where and how long? ______________________________

Does the family struggle with financial issues? ☐ Yes ☐ No Please explain ______________

____

Please list any religious affiliations ______________________________

Has a parent ever served in the military? ☐ Yes ☐ No

Please identify any legal issues involving your child ______________________________

Has your child been involved with the Department of Human Services (DHS)? ☐ Yes ☐ No
Please explain: (include situation, dates, who was involved, charges filed, case open/closed)

____

Check all the problems you would like to address today:
☐ Depression ☐ Anxiety ☐ Sleep/Appetite Problems ☐ Behavior Problems
☐ Drug/Alcohol Problems ☐ Suicidal Thoughts ☐ Other ______________________________

What is the most important problem you would like your doctor to address at your visit? (please be very brief as we will discuss everything in detail at your visit ______________________________

When did you first notice the problem/symptoms? ______________________________

List any mental health diagnosis your child has ever been told by a professional ______________

____

List any and all mental health medications your child has ever been prescribed by a professional

____

Has your child ever been admitted to a psychiatric hospital? ☐ Yes ☐ No If yes, please list when/where/why they were admitted first and most recently ______________________________

____

Has your child ever attempted to kill themselves? ☐ Yes ☐ No If yes, how many times?_____

What action did they attempt to end their life? (each time) ______________________________

____

Has your child ever cut, burn, pierced, or otherwise harmed themselves without the intent of ending their life? ☐ Yes ☐ No If yes, please explain briefly ______________________________

____

Does anyone in your family have mental health or significant medical problems? ☐ Yes ☐ No
If yes, please list ____

Has anyone in your family ever attempted suicide? ☐ Yes ☐ No If yes, who? _______________

Has anyone in your family ever had problems with drugs or alcohol? ☐ Yes ☐ No
If yes, who and what substance(s)? ______________________________________

Does your child use tobacco products? ☐ Yes ☐ No
If yes, how much/often (i.e., packs per day/week) ______________________________

Has your child ever drank an alcoholic beverage? ☐ Yes ☐ No If yes, how much/often? ________

Check all of the following substances your child has ever tried in the past:
☐ Cannabis/Weed ☐ PCP ☐ LSD ☐ Cocaine ☐ Mushrooms ☐ Ecstasy ☐ Peyote
☐ Bath Salts ☐ Methamphetamine/Speed ☐ Other ______________________________

Check all of the following prescription medications your child has taken in excess of the written prescription or obtained from a friend, family member, or on the street:
☐ Opiates/Pain Pills ☐ Stimulants/"Uppers" ☐ Benzodiazepines/Sedatives/"Downers"
☐ Other ____

List any medical problems and current medications your child has __________________________

____

List any surgeries your child has had in the past and the year you had them ___________________

____

Current Grade _____ **School they attend** ___________________________ **GPA** _______

Individualized Education Plan (IEP)/504 Plan ☐ Yes ☐ No If yes, why? __________________

____

Behavior problems? ____

Was your child held back in any grade? ☐ Yes ☐ No If yes, which grade and why? ___________

____

Expelled/Suspended from school? Yes ☐ No ☐ If yes, why? ______________________________

Does your child have close friends? (identify at school and/or home) ______________________________

____

Does your child have a history of fighting? ______________________________

Where was your child born? __________________ **Raised** (city) __________________

Problems during pregnancy or birth? ______________________________

Exposure to substances prenatally? ______________________________

Gestational week born? ________________ ☐ Natural ☐ C-Section

Developmental milestones (months) Crawling __________ Walking _________ First Words _________

Problems with (check all that apply): ☐ Speech ☐ Language ☐ Vision ☐ Hearing

List services used ____

Please review list of additional services/resources and check the ones you are interested in:

☐ Housing ☐ Food ☐ Employment/Job Skills ☐ Transportation ☐ GED

☐ Other (please list) ____

____

Welcome to our clinic and thanks for providing us with this information.

____ ________________

Patient Signature/Parent or Guardian if minor Date

____ ________________

Provider Signature Date

Place patient label here

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PHONE 405-214-5101

APPOINTMENT POLICY

Please be aware of the following guidelines for the appointment policy of CPNBHS. If you miss two consecutive appointments without notifying the receptionist within 24 hours in advance, your services may be suspended for three months. We ask that you call 24 hours in advance of your appointment should you need to cancel an appointment. If you have a consistent pattern of calling the day of your appointment to cancel you may also be suspended for three months. If you continually no-show appointments after re-instatement you may be placed on same-day status or be suspended from CPNBHS indefinitely. You have an option to engage in an appeal process for reconsideration. If you are suspended from services your medication refills will be honored for 30 days. You will be provided with alternative resources.

Statement of Confidentiality

In accordance with the stipulations of Federal Confidentiality regulations 42 CFR Part 2:

1. I agree to honor the confidentiality of staff and other clients.
2. What I see or hear in the agency remains in the agency.
3. I will not discuss anything that happens which involves others, and can expect the same from all other clients and staff.
4. Violation of this agreement may constitute grounds for termination of services.

____ _______________
Patient Signature/Parent or Guardian if minor Date

____ _______________
Provider Signature Date

Place patient label here

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CONSENT FOR SERVICES

Application is hereby made by the undersigned for voluntary admission for services at the Citizen Potawatomi Nation Behavioral Health Services, as a voluntary patient under the provisions of OS 43A Section 9-101. Please refer to the CPN Behavioral Health Program Overview for a description of the services offered.

I certify that I am _______ years of age. Voluntary admission may be made for any person eighteen (18) years of age or over on his/her own signature. Any person at least twelve (12) years of age may be admitted with the consent of such person and the consent of the person's parent or guardian. I have read, or had read to me, the following information about my rights.

1. All persons receiving services from this facility shall retain all rights, benefits and privileges guaranteed by the laws of the State of Oklahoma and the United States of America except those specifically lost through due process of law, OS 43A, Section 1-103(h).

2. All persons shall have the rights guaranteed by the Notification of Patient Rights, unless these standards or an order of a court of competent jurisdiction specifically authorizes an exception.

3. I have been given a summary or a full copy of my rights as a patient and fully understand the content of this document. I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate the services rendered.

4. I understand that I have the right to ask any questions I may have about the process, methods, duration, and goals of therapy; the right to discuss any concerns I may have about my progress in therapy; and the right to terminate therapy at any time.

5. I understand that one of my most important rights involves privacy and confidentiality. I understand that a confidential psychological record of the care and services I receive will be securely and privately maintained in order to provide quality care and to comply with certain legal and ethical requirements. I also understand that an electronic record will be maintained. CPNHS medical doctors and nurse practitioners who provide healthcare services on my behalf will also have access to my electronic mental health record with the exception of psychological test data. Also, the billing department, medical records, and administration may also have access on a need to know basis should services be billed, I sign a ROI, or if a complaint I shared requires clinic administration to investigate. I have received a copy of the **Notice of Practices to Protect the Privacy of Health Information** and I have been provided an opportunity to review the legal duties, privacy practices, and my rights regarding the use and disclosure of my confidential psychological information. I understand that the use and disclosure of my psychological information will not be permitted without my specific written authorization. I understand that any specific written authorization I provide may be revoked at any time by writing to this office. I understand there are certain legal and emergency situations in which it is required by law and/ or professional ethics that specific information obtained during treatment may be used and disclosed. The use and disclosure of specific psychological information have been described in the **Notice of Practices to Protect the Privacy of Health Information**. My signature below

acknowledges that I have read and understand the **Notice of Practices to Protect the Privacy of Health Information** and that this signature page will be kept in my psychological record.

6. I certify that I understand the contents of this document, I have read the **Notice of Policies to Protect Health Information**, and I give my written consent for psychological services.

7. I understand that OS 43A, Section 4-210 requires that each patient of this facility be charged for care and treatment provided. I have been given a copy of the current rate schedule and I understand that the payment of all charges is adjusted according to my financial ability to pay (if applicable). OS 43A, Section 4-202.

8. The goal of mental health treatment is the amelioration of psychological distress and interpersonal conflict and that process depends on trust and openness during treatment. Therefore, the patient agrees that if he/she requests the treatment professional's services, the patient is expected not to use information given to the treatment professional for the patient's own purposes in a legal proceeding of any kind. If the treatment professional is somehow legally compelled to attend a legal proceeding of any kind, the patient agrees and understands that: a) the professional will not render an opinion on the issues of divorce, parental fitness, child custody, disability, or any other legal or medical conclusion; and b) the professional will not render any testimony or make any statement of any kind absent an express, written waiver of confidentiality executed by the patient.

9. *<u>**Special notice for CPN Employees and patients who are related to or in some other way affiliated with a/an CPN Employee(s)**</u>: While CPNHS strives to maintain the upmost confidentiality, especially when it comes to behavioral health concerns; there are times when CPN employees other than your treatment provider will have access to your medical records including behavioral health notes. There may be situations where your information could be viewed by someone you are related to or otherwise affiliated with. This could potentially present conflicts of interest for you and/or the person viewing your information. There may be situations where conflicts of interest may prohibit continuation of care with your provider or in the CPN clinics. If such conflicts should arise you will be provided with appropriate referral information. If you have questions or concerns about this, please bring those up to your provider at the beginning of your appointment. By signing below, you indicate your understanding of the limits of confidentiality.

______________________________________ _______________
Patient Signature/Parent or Guardian if minor Date

______________________________________ _______________
Provider Signature Date

Place patient label here

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CERTIFICATION OF PROGRAM OVERVIEW, NOTIFICATION OF PATIENT RIGHTS AND PRIVACY NOTICE

(*This information can be found in the packet attached to the new patient application.)

I hereby certify that I have read or had read to me and received a synopsis of the CPNBHS Patient Bill of Rights, option to review 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), evacuation route, and program overview.

I understand that I can request or deny the full Mental Health and Drug or Alcohol Abuse Services Bill of Rights document OAC 450:15-3-6 through 450:15-3-25.

_________________ Received

_________________ Denied

I also acknowledge that my records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered to me.

In addition, I understand that I will be receiving education regarding HIV/AIDS, substance abuse disorders, if applicable.

____ ________________
Patient Signature Date

____ ________________
Parent or Guardian Signature Date

____ ________________
Witness Signature Date

Place patient label here

CHILD AND ADOLESCENT TRAUMA SCREEN (CATS)
CAREGIVER REPORT (AGES 3-17)

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark NO if it didn't happen to the child.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake or fire. ☐ Yes ☐ No
2. Serious accident or injury like a car/bike crash, dog bite or sports injury. ☐ Yes ☐ No
3. Robbed by threat, force or weapon. ☐ Yes ☐ No
4. Slapped, punched or beat up by someone in the family. ☐ Yes ☐ No
5. Slapped, punched or beat up by someone not in the family. ☐ Yes ☐ No
6. Seeing someone in the family get slapped, punched or beat up. ☐ Yes ☐ No
7. Seeing someone in the community get slapped, punched or beat up. ☐ Yes ☐ No
8. Someone older touching his/her private parts when they shouldn't. ☐ Yes ☐ No
9. Someone forcing or pressuring sex or when he/she couldn't say no. ☐ Yes ☐ No
10. Someone close to the child dying suddenly or violently. ☐ Yes ☐ No
11. Attacked, stabbed, shot at or hurt badly. ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. ☐ Yes ☐ No
13. Stressful or scary medical procedure. ☐ Yes ☐ No
14. Being around war. ☐ Yes ☐ No
15. Other stressful or scary event? ☐ Yes ☐ No
    a. Describe ____

Which one is bothering the child most now? ______________________________

If you marked any stressful or scary events for the child, then turn the page and answer the next questions.

CPN BEHAVIORAL HEALTH PROGRAM OVERVIEW

Welcome to the Behavioral Health Department. It is our hope that we can be of service to you by providing quality care for your emotional and mental wellbeing. We are an outpatient facility operating during regular clinic hours.

Referral - Behavioral health services are provided to clinic patients referred by their primary care providers or self-referred. Your initial contact with the receptionist will include completing forms to establish a separate behavioral health chart in the clinic. A therapist will be assigned and an appointment will be scheduled.

Assessment and Evaluation - Initial sessions range from 45 to 90 minutes in length that consist of a comprehensive interview by a therapist and may include other assessment questionnaires used to determine the severity of a problem.

Follow-up Sessions and On-going Treatment - Are scheduled to review assessments and determine what therapy services will be offered to address any potential problems. Discussions will include the initial diagnostic impression, available treatment options, recommended therapeutic interventions, frequency of services, limits to confidentiality, and your participation in developing a comprehensive treatment plan. On-going treatment will consist of follow-up sessions with you and your therapist or psychiatrist working towards completion of your treatment plan.

Therapeutic Interventions include:

Assessment/Evaluation - Pertaining to mental health and substance abuse issues.

Individual/Couples/Family Therapy - Appointments are scheduled for 45-90 minute sessions.

Group Therapy - For addiction treatment (alcohol/drug including nicotine) and coping skills therapy. Sessions range from one to two hours depending on the group. Alcohol and substance use groups meet on Mondays at 10am, Tuesdays at 5pm, Thursdays at 5pm, and Fridays at 10am.

Smoking Cessation Classes - Are offered several times throughout the year. This class is led by a licensed alcohol and drug counselor and meets on Wednesdays at 5pm.

Medication Management - A staff psychiatrist visit is for medication and on certain occasions brief psychotherapy. Psychiatric care is limited to a 30-45 minute initial visit and regularly scheduled 30 minute follow-up visits.

Confidential Records - Hard copies/paper charts are kept locked in a safe place for your right to privacy. Electronic behavioral health records are kept secure and only behavioral health staff members, and if applicable, CPNHS medical doctors and nurse practitioners who provide you with healthcare services, billing staff, if you sign a Release of Information, or if a complaint is shared that requires Clinic Administration to investigate (similar to Consent #5 of Patient Rights) have electronic access to your behavioral health records. Therapy sessions are held in the department and protected by locked entrances.

Consent for Release of Information - Is required to send behavioral health evaluation reports/records to other agencies and can be completed in Medical Records. Disability, parental fitness, child custody, inability to work determinations, and other legal or medical conclusions are not provided.

For parents of patients who are 17 and younger, we ask that you stay in the department for the duration of their session for safety purposes.

CPN BEHAVIORAL HEALTH NOTIFICATION OF PATIENT RIGHTS

1. Each patient has the right to be treated with respect, dignity and ethical treatment.
2. Each patient has a right to a safe, sanitary and humane treatment environment. In addition, every patient shall have a right to a humane psychological environment that protects him/her from harm or abuse, provides reasonable privacy, promotes personal dignity and provides opportunity for improved functioning.
3. Patients shall receive service or appropriate referral without discrimination as to race, color, sex, marital status, sexual orientation, gender identity and expression, pregnancy, religion, national origin, degree of disability or ability status. Patient's informed consent will also be obtained.
4. Deprivation of a patient's civil, political, and personal or property rights shall not occur without due process of the law. However, because of the patient's medical psychiatric condition, a physician may modify some of these rights.
5. Patients have the right to authorize release of their medical records and specify what will be shared after they have provided their written consent on an authorized release of information. Patients also have the right to request a treatment summary letter when they do not wish to release their record.
6. The patient has the right to refuse services. However, such a refusal may be in violation of probation, parole or court order, which would subject one to penalties.
7. An individual can expect an explanation concerning the reason he/she was refused services, if applicable.
8. Each patient shall be informed of present or future use of any audio recordings, videotapes, movies, photographs, in which he/she voluntarily participated with appropriate consent forms signed by the patient.
9. Non-Native CPN Employees and immediate family members may be responsible for services not covered by insurance. Every effort will be made to inform patient of cost for which s/he may be responsible. A fee schedule is available upon request. Please contact billing at the West Annex (PH: 405-964-4025) for any explanation of your charges. Non-Native CPN employee immediate family members have a $25 co-pay due prior to the appointment.
10. Each patient shall be provided with prompt, competent, appropriate and individualized treatment plan. A patient shall participate in his/her treatment program and may consent or refuse to consent to the proposed treatment. The right to refuse or refuse to consent may be abridged for those patients adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law.
11. No patient shall be required to participate in any research project or medical experiment without his/her informed consent as defined by law. Refusal to participate shall not affect the services to the patient.
12. Each patient has the right to request the opinion of an outside medical or psychiatric consultant at his/her own expense, or a right to an internal consultation.
13. Patients have a right to assert a grievance through a facility grievance procedure, and have said grievance promptly and fairly heard. Patients can complete a patient satisfaction and complaint form, have the right to contact CPNHS administration at 405-964-4900 and also have the right to contact their CPNBHS provider's licensing board.
14. No patient shall be retaliated against or subject to any adverse change of conditions or treatment solely or partially because of his/her having asserted his/her rights.
15. A patient has the right to confidentiality of patient related information and records as otherwise provided in state and federal statutes.
16. Patient has the right to permit or decline family/significant others in participating in treatment and treatment planning.

CPN BEHAVIORAL HEALTH NOTICE OF MENTAL HEALTH PROVIDERS POLICIES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Citizen Potawatomi Nation Behavioral Health Services is required to maintain the privacy of your health information and provide you with this Notice of legal duties and privacy practices.

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

CPN BHS may ***use*** or ***disclose*** your ***protected health information (PHI)*** for ***treatment***, ***payment***, and ***health care operations*** purposes with your ***consent***. To help clarify these terms, here are some definitions:

- **"*PHI*"** refers to information in your health record that could identify you.
- **"*Treatment, Payment, and Health Care Operations*"**
  - ***Treatment*** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
  - ***Payment*** is when I obtain reimbursement for your healthcare. Examples of payment are when I or billing disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ***Health Care Operations*** are activities that relate to the performance and operation of our practices. 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 my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"*Disclosure*"** applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

CPN BHS may ***use*** or ***disclose PHI*** 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 I am asked for information for purposes outside of ***treatment***, ***payment***, and ***health care operations***, I will obtain an ***authorization*** from you before releasing this information. I will also need to obtain an ***authorization*** before releasing your psychotherapy notes, if applicable. **"*Psychotherapy notes*"** (if applicable) are notes about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your counseling record. These notes are given a greater degree of protection than ***PHI***.

You may revoke all such ***authorizations*** (of ***PHI*** and ***therapy notes***) at any time,provided each revocation is in writing. You may not revoke an ***authorization*** to the extent that (1) I have relied on that ***authorization***; 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.

III. Uses and Disclosure with Neither Consent nor Authorization

CPN BHS may ***use*** or ***disclose PHI*** without your ***consent*** or ***authorization*** in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child under the age of 18 years is the victim of abuse or neglect the law requires that I make a report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (i.e., elderly, disabled, incapacitated) is suffering from abuse, neglect, or exploitation, I am required by law to make a report to either the Oklahoma Department of Human Services, the District Attorney's Office, or the Municipal Police Department as soon as I become aware of the situation.
- **Health Oversight:** If you file a disciplinary complaint with a state board they would have the right to view your relevant confidential information as part of the proceeding.
- **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 I will not release the information without 1) written authorization from you or your personal or legally appointed representative, or 2) 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.
- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware, and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- **Worker's Compensation:** If you file a worker's compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, the Attorney General, a District Attorney (or a designee for any of these) to examine your records relating to the claim.
- **Appointment Reminders:** If there is a need to contact you regarding appointments.

IV. Patient's Rights and Clinical Duties

Patient's Rights:

- ***Right to Request Restrictions*** - You have the right to request restrictions on certain ***uses*** and ***disclosures*** of ***PHI*** about you. However, I am not required to agree to the restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** - You have the right to request and receive confidential communications of ***PHI*** by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will contact you at another location.)

- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) of ***PHI*** in my counseling and billing records used to make decisions about you for as long as the ***PHI*** is maintained in the record. I may deny your access to ***PHI*** under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- ***Right to Amend*** - You have the right to request an amendment of ***PHI*** for as long as the ***PHI*** is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- ***Right to an Accounting*** - You generally have the right to receive an accounting of disclosures of ***PHI*** for which you have neither provided ***consent*** nor ***authorization*** (as described in section III. Of this ***Notice***). On your request, I will discuss with you the details of the accounting process.

- ***Right to a Paper Copy*** - You have the right to obtain a paper copy of this Notice from me.

Clinical Duties:

- CPNBHS is required by law to maintain the privacy of ***PHI*** and to provide you with a ***Notice*** of my legal duties and privacy practices with respect to PHI.

- CPNBHS reserves the right to change the privacy policies and practices described in this ***Notice***. Unless CPNBHS notifies you of such changes, however, I am required to abide by the terms currently in effect.

- If CPNBHS makes revisions to the policies and procedures, CPNBHS will notify you in writing by mail or at your next appointment.

V. Questions and Complaints

If you desire further information about privacy practices or if you have questions, please contact me. If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact: Mr. Chris Skillings, Health Director for the Citizen Potawatomi Nation Health Services.

You may also send a written question or complaint to the Secretary of the United States Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the United States Department of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

These Policies and Practices went into effect on April 14, 2003.

I will limit the uses or disclosures that I will make as follows:

Parents or legal guardians of client(s) who are minor children/adolescents will be asked to agree to the confidentiality of their child/adolescent's communications to me and, as such, will not be permitted to examine or have a copy of their child's record.

I reserve the right to change the terms of this ***Notice*** and to make the new ***Notice*** provisions effective for all ***PHI*** that I maintain. I will provide you with a revised ***Notice*** should that occur.

Emergency Situations:
Crisis Hot Line at 1-800-522-9054
Or proceed to the nearest Hospital Emergency Room.

RESOURCES

Suicidal/Homicidal Crisis

CPN Behavioral Health
26 Father Joe Murphy Drive
Shawnee, OK 74801
405-214-5101

CPN Tribal Police
405-878-4818 or 911 for emergency

Griffin Memorial Hospital
900 E. Main St. Norman,
OK 73071
405-321-4880

Children's Recovery Center
320 12TH Ave. NE
Norman, OK 73071
405-364-9004

Red Rock Behavioral Health Services
101 N. Union
Shawnee, OK 74801
405-275-7100

National Suicide Prevention Line
1-800-273-8255

Norman Adult Crisis Stabilization Unit
900 E. Main
Norman, OK 73071
405-307-4800

Veterans Crisis Line
1-800-273-8255

PRESS 1

Free information line with resources in the OKC metro area 211 (**including Shawnee**)

Dial: 211 toll free

Text: your zip code to 898211

Email: Help@211info.org

The Trevor Project Lifeline (Trevor Chat) (LGBTQ2)
1-866-488-7386

Crisis Text Line
Text "Home" to 741741

Intimate Partner Violence/Family Violence

911 for an emergency

National Domestic Abuse Hotline
1-800-799-SAFE (7233)

National Sexual Assault Hotline
1-800-656-4673

CPN House of Hope
1310 Gordon Cooper Drive
Shawnee, OK 74801
405-275-3176

Child Abuse and Neglect Hotline
1-800-522-3511

Strong Hearts Native Helpline
1-844-7NATIVE (762-8483)

YWCA
2460 NW I-44 Service Rd.
Oklahoma City, OK 73112
405-948-1770

Project Safe
313 N. Union Ave. Shawnee,
OK 74801
405-273-9953

Substance Use Emergency

911 for an emergency

CPN Behavioral Health
26 Father Joe Murphy Dr.
Shawnee, OK 74801
405-214-5101

CPN Health Clinic
2307 S. Gordon Cooper Dr.
Shawnee, OK 74801
405-273-5236

Gateway to Prevention and Recovery
1010 E. 45th St.
Shawnee, OK 74804
405-273-1170

CREOKS
600 W. Independence St.
Shawnee, OK 74804
405-275-1844

The Recovery Center (TRC)
1215 NW 25th St.
Oklahoma City, OK 73106
405-525-2525

NARCAN® (naloxone HCI), nasal spray for use in the event of an opioid overdose, is available at CPN Public Health and Gateway to Prevention and Recovery in Shawnee, Oklahoma.