PATIENT CONSENT AND FINANCIAL AGREEMENT

Kalispell, Montana

Patient Name: _____ Patient DOB: _____

Please Print

Welcome to Logan Health. Thank you for choosing us for your care and treatment. Logan Health is an integrated health system that includes a number of organizations and Healthcare Services providers. Your consent covers services provided at all Logan Health entities.

Please review this Agreement carefully. Except in cases of emergency care, we must have a signed and dated Patient Consent and Financial Agreement before Healthcare Services (defined below) can be provided to you. If you have any questions about this Agreement, our Logan Health staff will be happy to answer your questions before you sign.

If, at a later date, you have additional questions about your medical bills or need to make corrections to the information you have provided to Logan Health, please contact the Logan Health Patient Accounting office by calling (406) 756-4408, Monday through Friday, except holidays, from 8:00 a.m. through 5:00 p.m.

CONSENT FOR TREATMENT AND CARE

You hereby consent to any Healthcare Services (as defined below in this paragraph) provided by Logan Health and Healthcare Services providers who are independent from Logan Health but who are authorized to provide Healthcare Services to you as a Logan Health patient. These independent, non-Logan Health-employed providers include, but are not limited to physician and other medical and allied health professional staff members of Glacier Regional Pathology, Ltd.; Clinical Pathology Associates, LLC; Northern Rockies Anesthesia Consultants, PLLC; Northwest Imaging, PC; Silvertip Emergency Physicians, PC (collectively, "Logan Health Affiliated Providers") and outside reference laboratories. You understand and agree that resident physicians and other Healthcare Services education students may participate in or be observers of the Healthcare Services you receive at Logan Health. These residents and students will be supervised by qualified instructors and Logan Health staff. You can decline care by supervised resident physicians and Healthcare Services education students by discussing it with your provider(s) prior to care being rendered. Your Healthcare Services may be provided in person or via telehealth technology and may include, but are not limited to, hospital inpatient, outpatient, and/or emergency services; physician office services; diagnostic procedures; transportation; nursing care; and other Healthcare Services and products. You acknowledge that no guarantees have been made regarding the outcome of these Healthcare Services. If you are not able to sign this Agreement personally, then the consent for your care and treatment: (1) may be given by your representative(s) who are legally authorized to make decisions and sign this Agreement on your behalf, or (2) shall be implied in cases of emergency.

REPORTING OF IMMUNIZATION RECORDS

The Montana Department of Public Health and Human Services (DPHHS) has requested that we seek your consent to share your/your child's immunization data with the DPHHS Immunization Information System (IIS). DPHHS may release IIS data to other public health agencies as well as to your/your child's healthcare providers to assist in your/your child's medical care and treatment. In addition, DPHHS may release IIS data to schools in order to comply with immunization requirements. You can always choose to opt out at a later time and/or have your/your child's immunization record removed at any time by contacting your county's health department. You understand that any such revocation will not be effective as to uses and/or disclosures already made prior to opting out.

THIS IS NOT A CONSENT TO RECEIVE ANY IMMUNIZATION, IT IS ONLY A CONSENT TO REPORT YOUR/YOUR CHILD'S IMMUNIZATION DATA TO DPHHS IIS. If you are OPTING OUT and do not wish for your/your child's immunization data to be provided to DPPHS, check the box, sign and date in the area below.

☐ **OPT OUT** OF THE DPHHS IMMUNIZATION INFORMATION SYSTEM

_____ _____

Name of Patient Date Signature of Patient/Parent, Authorized Representative or Guardian, if applicable

FINANCIAL AGREEMENT

AGREEMENT TO PAY CHARGES AND BILLING STATEMENTS — In consideration of the Healthcare Services provided to you, you and/or any individuals who are directly responsible for your medical bills, such as a parent or guardian, (collectively, "Guarantors") agree to pay Logan Health's billed charges related to those Healthcare Services ("Charges"), minus any contractual reductions from the Charges agreed to by Logan Health with your Health Plan Payor (if applicable) and any other reductions to which you may be entitled, such as under the Logan Health financial assistance policy. You understand and agree that: (1) any Logan Health Affiliated Providers that provide Healthcare Services to you in connection with your care and treatment at Logan Health may have separate billing and collection practices that result in one or more separate bills for which Guarantors are responsible to pay; (2) the terms of this Agreement prevail over any conflicting terms and conditions in any other contract or plan to which you claim to be a party or a beneficiary; (3) it is possible that your Health Plan will determine that Healthcare Services provided to you are not Covered Services and that you will be responsible for paying for those Healthcare Services; and (4) the terms of this Agreement are governed by the laws of the State of Montana.

FINANCIAL ASSISTANCE— Logan Health has a Financial Assistance policy available to patients who qualify. If you are interested in learning more, please ask our staff for a copy of the policy. The Financial Assistance Policy is available on the Logan Healthwebsite under the heading "Pay Bill."

PATIENTS WITH OUT-OF-NETWORK INSURANCE [OTHER HEALTH PLAN PAYOR [HEALTH SHARE PRODUCT - You understand and agree that except when prohibited by applicable law, Logan Health may collect its charges from guarantors when Logan Health does not have a written contractual agreement with an insurance company, other health plan Payor or health share product outlining an agreed upon rate of payment for the Healthcare Services provided (called "out-of- network"). You understand and agree that when receiving Healthcare Services from Logan Health on an out-of-network basis, Guarantors may also be required to make payment at the time of service.

PAYMENT — Guarantors may make payment to Logan Health: (1) at the time Healthcare Services are provided to you; (2) in accordance with billing statements received from Logan Health; or (3) in accordance with a payment arrangement schedule that is agreed upon by both Logan Health and Guarantor(s). If Guarantors fail to make any scheduled payment when due, you understand and agree that: (1) Logan Health may declare the entire balance to be immediately due and payable, and (2) Guarantors will be responsible for all costs associated with collection of the owed charges, including reasonable attorneys fees. You acknowledge and agree that payments to Logan Health Affiliated Providers must be made to them in accordance with their payment rules. No partial payment of the amount owed by Guarantors to Logan Health (whether the payment says it is in full payment or not) will be treated as full payment without a specific separate written agreement between Guarantors and Logan Health that is signed by both parties. Logan Health may also assign past due accounts to third party collection agencies.

THIRD PARTY LIABILITY — In the event that any third party is or could be liable for part or all of the charges for the Healthcare Services provided to you (such as due to an automobile accident), you acknowledge that Guarantors remain responsible for the portion of the Charges that you are responsible to pay, but Logan Health is also legally authorized to bill for and recover from that third party the full charges for the Healthcare Services. Logan Health may do this whether or not Logan Health has also submitted a bill for the services to any federal, state, or private healthcare insurance/health benefits plans (collectively a "Health Plan Payor") covering you. Guarantors will not be responsible for any amounts in excess of the portion of the charges that you are responsible to pay, but Logan Health may recover from the third party an amount that permits Logan Health to receive up to the full charges for the Healthcare Services provided. Guarantors also acknowledge that Logan Health may submit a Healthcare Provider/ Facility Lien, as allowed by Montana Code Annotated Title 71, Chapter 3, Part 11, to the third party. To the extent any medical care I receive under this Care Agreement is rendered in connection with a vehicle accident, I hereby designate Logan Health and/or its representatives, designees or agents as my representative for purposes of requesting and securing copies of any accident reports under 61-7-114(2)(b), MCA.

see other side

OVERPAYMENTS'— Please let us know if your address changes so that we can contact you in the event that your account is overpaid and you are entitled to a refund in accordance with this paragraph. If your account is overpaid by. less than $15.00, you agree that the amount is too small to refund and that we may take either of the following actions in the following order: (1) apply the overpayment amount to any other outstanding accounts that you have with us, or (2) if you do not have any other outstanding accounts with us, we may write off the overpayment amount. [f your account is overpaid by $15.00 to $49.99. we will attempt to contact you and provide you with a refund of the overpayment amount. If, after one year, we have not been able to contact you, you agree that we may take either of the following actions in the following order: (1) apply the overpayment amount to any other outstanding accounts that you have with us or, (2) if you do not have any other outstanding accounts with us, we may write off the overpayment amount. If your account is overpaid by $50.00 or more. we will attempt to contact you and provide you with a refund of the overpayment amount. If, after three years, we have not been able to contact you, then pursuant to Montana's Unclaimed Property Act, we will send the overpayment amount, minus a statutorily allowed dormancy charge of $10 per year, to the Montana Department of Revenue.

NOTICES OF NON-COVERAGE

If it is determined at any time, prior to or during your hospital stay, that your medical services and/or inpatient hospitalization are considered not medically necessary, not being delivered in the appropriate setting, or are deemed to be custodial in nature, a Hospital Issued Notice of Non-coverage (HINN) or Medicare Waiver/Advanced Beneficiary Notice (ABN) will be delivered to you. The notification will explain any services you may be financially responsible for, the estimated costs associated with those services, as well as your rights to request an expedited review by the QIO.

AUTHORIZATION

Without waiver or limitation of the above Financial Agreement, you hereby: (I) authorize Logan Health, on your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and other responsible third party providing coverage for, or who may be otherwise liable for, payment of any of the charges for the Healthcare Services provided to you ("Responsible Third Parties"); and (2) direct those Health Plan Payors and Responsible Third Parties to which Logan Health submits a claim for payment to make payment(s) directly to Logan Health. You understand and agree that Logan Health: (1) is not required to submit a claim for payment to anyone other than Guarantors; but (2) may choose to submit a claim to one or more of your Health Plan Payors and Responsible Third Parties. This authorization is limited only to the rights, on your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and Responsible Third Parties. It does not entitle Logan Health to any other rights or bind Logan Health to any responsibilities that you may have under any Health Plan Payor agreements, third party liability agreements or policies or any other theories of coverage or liability. You hereby consent also to Logan Health providing notice of this authorization to your Health Plan Payors and other Responsible Third Parties.

APPOINTMENT OF Logan Health (Logan Health) AS AUTHORIZED REPRESENTATIVE

I understand that Logan Health may assist in pursuing a claim or appeal of a denied claim. I authorize and appoint Logan Health to act on my behalf and/or on behalf of my covered child/ dependent (under 18 years of age) as my authorized representative with any insurance carrier with whom valid insurance coverage exists for medical services. I further direct that any payment made by any insurance carrier as a result of a successful appeal is to be paid directly to Logan Health. This authorization and appointment will remain valid until such time as I revoke this authorization and appointment in writing to Logan Health.

RELEASE OF INFORMATION

You acknowledge that Logan Health and Logan Health Affiliated Providers are authorized by law to release medical and account information necessary for the purposes of treatment, payment, and healthcare operations. This information may be released to Health Plan Payors, liability insurance companies, billing companies, collection agencies, attending/consulting healthcare providers, governmental programs or -medical review organizations and otherwise as permitted or required by law.

HEALTH INFORMATION EXCHANGE

Logan Health may share information that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (HIES) in which we participate. For example, information about your past medical care and current medical conditions and medications may be available to us or to your non-Logan Health primary care physician or hospital, if they participate in the HIE. Exchange of health information may provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. If you are OPTING OUT and do not wish for your/your child's PHI to be released to the HIE, check the box, sign and date in the area below.

☐ **OPT OUT** OF THE HEALTH INFORMATION EXCHANGE

Name of Patient _____ Date _____ Signature of Patient/Parent, Authorized Representative or Guardian, if applicable _____

CONSENT TO CONTACT

You agree that, in order for Logan Health and/or Logan Health Affiliated Providers to request your feedback about the Healthcare Services provided to you, to service your account, or to collect any amounts you may owe, Logan Health, Logan Health Affiliated Providers and their business associates, including without limitation any independent contractors, account management companies or collection agencies, may contact you by telephone, SMS text message or email at any cellular or residential telephone number or email address provided during your registration process. These methods of contact may include auto-dialed, prerecorded and/or artificial voice message calls or texts as permitted by law.

PERSONAL VALUABLES

You acknowledge that Logan Health maintains a safe for securing money and/or other valuables. Logan Health shall not be liable for the loss of or damage to your money, valuables, articles of unusual value, or any other personal property if not deposited with Logan Health for storage in Logan Health's safe.

BY SIGNING BELOW, you CONFIRM THAT YOU: (1) UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT, (2) HAVE HAD AN OPPORTUNITIEY ASK QUESTIONS ABOUT THIS AGREEMENT AND (3) HAVE RECEIVED AND REVIEWED AND, [F NEEDED, COMPLETED THE FOLLOWING:

- **FEDERAL TRUTH IN LENDING ACT NOTIFICATION**
- **PATIENT BILL OF RIGHTS & RESPONSIBILITIES**
- **Logan Health JOINT NOTICE OF PRIVACY PRACTICES**
- **ADVANCE DIRECTIVE —You have been advised of your right to formulate and execute an Advance Directive and have been provided with written information regarding the same.**
- **AN "IMPORTANT MESSAGE FROM MEDICARE FOR MEDICARE BENEFICIARIES" or "IMPORTANT MESSAGE FROM TRICARE FOR TRICARE BENEFICIARIES" (Medicare and Tricare Inpatients, only)**

Patient Signature/Authorized Representative/Guarantor _____ Date _____

If an Authorized Representative/Guarantor, the nature of the relationship to the Patient: _____

Patient Name _____ Acct # _____

Witness _____ MRN # _____

ORIGINAL TO MEDICAL RECORDS OR SCANNED TO ACCOUNT • PHOTOCOPY TO PATIENT

LOGAN HEALTH

NOTICE OF NON-PARTICIPATING PROVIDER STATUS

You have the right to receive health care services from a health care provider of your choosing.

However, it is important for you to understand the financial implications of receiving care from a health care provider who is not a "participating provider" (also called an 'tin network provider") in your health care benefits plan.

Logan Health, including its hospitals, employed physicians and other health care services suppliers (a "health care provider"), are Non-Participating Providers because they DO NOT have a contract with your health care benefits plan.

What is a "Non-Participating Provider"? A Non-Participating Provider is a health care provider that does not have a contract with your health care benefits plan. This means that the health care provider is not obligated to directly bill your health care benefits plan or to accept the payment rates offered by your health care benefits plan. You are personally responsible for payment of the charges by the health care provider. You will need to deal directly with your health care benefits plan to get whatever reimbursement you may be entitled to.

You are choosing to receive health care services from a Logan Health health care provider. This means that, unless you qualify for other adjustments to the amount of your bill, you are required to pay for the full amount of your care out of your own pocket. An example of an adjustment would be qualifying for financial assistance under the Logan Health Financial Assistance Policy. Except for emergency services, you may be required to pay for all or a portion your health care services at or before the time they are provided or make other payment arrangements with the Logan Health Patient Accounts Department.

You may be able to receive reimbursement from your health care benefits plan for some or all of the amounts that you pay for your health care services that are provided by Logan Health health care providers. You will have to contact your health care benefits plan directly and follow its rules. Upon request, Logan Health will provide you with a copy of an itemized statement of the health care services that you received from us and the charges for those services. However, it is your obligation to file a claim with your health care benefits plan and Logan Health is not obligated to accept the payment rates offered by your health care benefits plan.

By signing below, you acknowledge the following:

1. You are aware that your Logan Health health care provider does not participate in your health care benefits plan.
2. You understand that you will be responsible for the costs of the health care services to be provided to you.
3. You understand that you will be responsible for seeking reimbursement from your health care benefits plan and that there is no guarantee that you will be fully reimbursed for the costs of your care by your health care benefits plan.
4. You are voluntarily choosing to receive services from Logan Health.

_____

Printed Name of Patient (or Parent or Legal Guardian, as applicable, and state the relationship)

_____

Signature of Patient (or Parent or Legal Guardian, as applicable)

Date:

_____

NOTICE REGARDING VOLUNTARY ADMISSION

You have been admitted to Logan Health Behavioral Health on a voluntary basis. However, it is important that you know your legal rights regarding a voluntary admission. Per Montana Code Annotated §53-21-111, should you wish to terminate your admission prior to discharge by a physician, such a request must be made in writing. Your request may not be acted upon immediately, and you may be held involuntarily for up to 5 days after requesting release. In addition, the fact that you are here voluntarily does not impact your provider's ability to request involuntary commitment if your provider deems the same appropriate for your condition and mental health needs.

I acknowledge by signing below I am voluntarily applying to Logan Health Behavioral Health for admission and I confirm that I understand and agree to the terms of this notification.

Patient Signature_____ Date_____ Time _____

Printed Name_____

Legal Representative _____ Date_____ Time _____

Printed Name_____ Relationship To Patient_____

Witness to Signature Only _____ Date _____ Time_____

Printed Name_____

Logan Health Behavioral Health

200 Heritage Way, Kalispell, MT 59901

NOTICE REGARDING

VOLUNTARY ADMISSION

8765-244 4/21

Policy #PTC2060 01/20; 4/21

CONDITION OF ADMISSION

1. CONSENT TO PHOTOGRAPH: I agree to allow the hospital to take my photograph to be used for purpose of identification and for giving medications.

2. VIDEO SURVEILLANCE: The Behavioral Health Unit has constant video surveillance in common areas for patient safety.

3. CONSENT TO SEARCH: It has been explained to me, and I understand, that as a condition of admission to Logan Health Behavioral Health, that:
   - my belongings will be searched for alcohol, drugs, and contraband upon admission, after passes, and after visitors; and
   - a member of the hospital staff may search my clothing and my body for alcohol, drugs, and contraband upon admission, after passes, and after visitors; and
   - during my hospitalization searches will be initiated by staff at any time to ensure patient safety.

Patient Signature _____ Date _____ Time _____

Printed Name _____

Legal Representative _____ Date _____ Time _____

Printed Name _____ Relationship To Patient _____

Witness to Signature Only _____ Date _____ Time _____

Printed Name _____

I have conducted an authorized search of the patient's body, as well as the clothes he or she is wearing on admission as outlined in the Condition of Admission.

Staff Signature _____

Date _____

Logan Health Behavioral Health
200 Heritage Way, Kalispell, MT 59901

CONDITION OF ADMISSION

8765-145 7/21
Policy #PTC8015 01/20; 4/21

Logan Health Behavioral Health

CERTIFICATION OF PATIENT RIGHTS

This is to certify that I have received a copy of the Summary of Patient Rights on the date indicated below. I understand that I am asked to read this information at my convenience and that I can discuss with Logan Health Behavioral Health staff any questions I have regarding the information provided.

Signature of patient:_____ Date: _____ Time: _____

Signature of Parent/Guardian: _____ Date: _____ Time: _____

Witness:_____ Date: _____ Time: _____

COMPLAINT/GRIEVANCE PROCEDURE:

If you cannot resolve your complaint with staff, you have the right to submit a written complaint to the Patient Advocate.

- Write down your complaint.
- Give your note to the Charge Nurse, stating that you would like it to go to the Patient Advocate or you may call **(406) 751-5434**. Our Patient Advocate will talk to you about your complaint as soon as possible.
- An investigation will take place to learn all of the facts about your complaint.
- Every effort will be made to resolve the complaint.
- The Patient Advocate will speak to you about the outcome of the investigation.

Logan Health Behavioral Health
200 Heritage Way,
Kalispell, MT 59901

Emergency Contact Information Form

Patient Name: _____
Last First MI

Phone: Home: _____ Cell: _____

Email Address: _____

Address: _____
Street City State Zip Code

Primary Emergency Contact Name: _____
Last First

Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Secondary Emergency Contact Name: _____
Last First

Relationship:

Phone: Home: Cell: Work:

Logan Health Behavioral Health
200 Heritage way Kalispell, MT 59901

EMERGENCY CONTACT

8765-245 7/21

ADOLESGENT VISITATION LIST

Visitors must be **over 18** years of age and an **immediate relative**, show proof of identification and children under 18 must be accompanied by an authorized adult. Other visitors include probation officers, therapists, clergy, legal representatives and sponsors. These people, must be on the list below to be allowed visiting privileges- Names on the visitor and phone lists must be approved by the Treatment Team. *(Staff must initial verbal authorizations)

Visitor Name	Relationship	Reason for Visit	Auth. Date & Initial	Revocation Date

ADOLESCENT PHONE LIST

All incoming calls will be identified by a **Code Name**, as listed below. It is the responsibility of the custodial parent(s), legal guardian to determine the Code Name and give it to the authorized callers on the list below. * (Staff must initial verbal authorizations)

Caller Name	Relationship	Phone #	Auth. Date & Initial	Revocation Date

My child/adolescent may participate in both on/off campus activities, as deemed appropriate, while an inpatient at Pathways Treatment Center.

Custodial Parent(s) Signature: _____ Date_____

Witness Signature: _____ Date_____

CODE NAME: _____

No contact names: _____

Logan Health Behavioral Health
200 Heritage way Kalispell, MT 59901

ADOLESCENT VISITATION LIST

8765-171 7/21

LOGAN HEALTH

Influenza Vaccination Consent Form

Last Name: _____ First Name: _____ Date: _____

Screening for influenza vaccine eligibility	Please mark your response
1. Do you have a severe allergy to eggs?	Yes ☐ No ☐
2. Have you ever had a life-threatening reaction to the influenza vaccine?	Yes ☐ No ☐
3. Do you have a history of GuiMain-Barre Syndrome?	Yes ☐ No ☐
4. Are you moderately or severely ill today? (fever >100.4F, CoVid 19 illness)	Yes ☐ No ☐
5. Are you pregnant?	Yes ☐ No ☐

If yes to any questions 1-3 then DO NOT vaccinate with influenza vaccine. If yes to question 4/ WAIT until patient has recovered. [If yes to question 5, Flu vaccines are recommended and indicated throughout pregnancy.

CONSENT

I have read or had explained to me the Vaccination information Statement about influenza vaccination and I understand the benefits and risks of influenza vaccination. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request).

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to patient: _____

Witnessed by: _____ Date: _____

11/2021

LOGAN HEALTH BEHAVIORAL HEALTH
200 Heritage Way ~ Kalispell, MT 59901 Phone: (406)756-3950 Fax: (406) 756-3957

Patient Information: Name _____ DOB:_____ Phone: _____
SSN: _____ Fax: _____

Permission is hereby given to EXCHANGE information with:

Logan Health Behavioral Health
200 Heritage Way
Kalispell, MT 59901
Phone: 406-756-3950 Fax: 406-756-3957

AND: Organization/Facility/Person: _____ Relationship: _____
Street Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Health Information to be released Please Initial:

____ Other _____
____ Psychiatric Evaluation/Consult ____ IM H&P/Consult
____ Discharge Summary ____ Progress Notes ____ ER Report
____ Medications ____ Laboratory Reports
____ Assessments: Psychiatric Evaluation/Consult, IM H&P, & Discharge Summary
____ Logan Health Behavioral Health Packet: Demographic Sheet, Psychiatric Evaluation, Psychiatric Consult (if applicable), IM H&P, Medications & Safety Plan, & Discharge Summary

Type of Release: ____ Verbal Exchange Only (No records) ____ Hard Copies (paper) ____ Electronic

Disclosure Method: ____ Mail ____ Fax _____ ____ Pick up by patient/authorized designee (requires photo ID)

This information may be disclosed to and used by the above identified individual or organization: (Use additional forms if more than one recipient.)

Information to be used for the purpose of:

☐ Requested by Patient ☐ Continuum of Patient Care ☐ Other_____

Authorization:

- Copy Service Fee: I understand there will be a charge for copying records. The charge for copying records includes: a $15.00 Service Fee and 50 cents per page.
- I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and genetic information. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by CFR Part 2).
- This authorization does not apply to psychotherapy notes.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- If I fail to specify an expiration date, event or condition, this authorization will expire in six months. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
- I understand that, if I have been asked to sign this authorization by a healthcare entity that is covered by the HIPAA Privacy rules, I am to be given a copy of this signed authorization.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Patient Name_____ Patient Signature_____ Date_____
Parent/Legal Guardian Name_____ Parent/Legal Guardian Signature_____ Date_____
Witness Name_____ Witness Signature_____ Date_____

Revocation of Authorization – As noted in the Logan Health Joint Notice of Privacy Practices:

- I understand that I may revoke this authorization in writing at any time by contacting Logan Health Behavioral Health.
- I understand that if I revoke this authorization, this revocation will not apply to information that has already been released in response to this authorization.

I revoke (cancel) this Authorization to Disclose Health Information previously signed on: Date _____

Patient Name_____ Patient Signature_____ Date_____
Parent/Legal Guardian Name_____ Parent/Legal Guardian Signature_____ Date_____
Witness Name_____ Witness Signature_____ Date_____

LOGAN HEALTH BEHAVIORAL HEALTH
200 Heritage Way ~ Kalispell, MT 59901 Phone: (406)756-3950 Fax: (406) 756-3957

Patient Information: Name _____ DOB:_____ Phone: _____
SSN: _____ Fax: _____

Permission is hereby given to EXCHANGE information with:

Logan Health Behavioral Health
200 Heritage Way
Kalispell, MT 59901
Phone: 406-756-3950 Fax: 406-756-3957

AND: Organization/Facility/Person: _____ Relationship: _____
Street Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Health Information to be released Please Initial:

____ Other _____
____ Psychiatric Evaluation/Consult ____ IM H&P/Consult
____ Discharge Summary ____ Progress Notes ____ ER Report
____ Medications ____ Laboratory Reports
____ Assessments: Psychiatric Evaluation/Consult, IM H&P, & Discharge Summary
____ Logan Health Behavioral Health Packet: Demographic Sheet, Psychiatric Evaluation, Psychiatric Consult (if applicable), IM H&P, Medications & Safety Plan, & Discharge Summary

Type of Release: ____ Verbal Exchange Only (No records) ____ Hard Copies (paper) ____ Electronic

Disclosure Method: ____ Mail ____ Fax _____ ____ Pick up by patient/authorized designee (requires photo ID)

This information may be disclosed to and used by the above identified individual or organization: (Use additional forms if more than one recipient.)

Information to be used for the purpose of:

☐ Requested by Patient ☐ Continuum of Patient Care ☐ Other_____

Authorization:

- Copy Service Fee: I understand there will be a charge for copying records. The charge for copying records includes: a $15.00 Service Fee and 50 cents per page.
- I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and genetic information. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by CFR Part 2).
- This authorization does not apply to psychotherapy notes.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- If I fail to specify an expiration date, event or condition, this authorization will expire in six months. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
- I understand that, if I have been asked to sign this authorization by a healthcare entity that is covered by the HIPAA Privacy rules, I am to be given a copy of this signed authorization.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Patient Name_____ Patient Signature_____ Date_____
Parent/Legal Guardian Name_____ Parent/Legal Guardian Signature_____ Date_____
Witness Name_____ Witness Signature_____ Date_____

Revocation of Authorization – As noted in the Logan Health Joint Notice of Privacy Practices:

- I understand that I may revoke this authorization in writing at any time by contacting Logan Health Behavioral Health.
- I understand that if I revoke this authorization, this revocation will not apply to information that has already been released in response to this authorization.

I revoke (cancel) this Authorization to Disclose Health Information previously signed on: Date _____

Patient Name_____ Patient Signature_____ Date_____
Parent/Legal Guardian Name_____ Parent/Legal Guardian Signature_____ Date_____
Witness Name_____ Witness Signature_____ Date_____

ADOLESCENT DEVELOPMENTAL HISTORY

Date_____ Completed by _____ Relationship _____

Family Physician _____

Address _____ Phone _____

Mother's Name _____ (**CIRCLE ONE** - Natural, Adoptive, Step, Foster)

Mother's Age _____ Education (Highest Level Completed) _____ Occupation _____

Father's Name _____ (**CIRCLE ONE** - Natural, Adoptive, Step, Foster)

Father's Age _____ Education (Highest Level Completed) _____ Occupation _____

Marital Status of natural parents of child **(check all that apply)**

_____ Married
_____ Not married
_____ One Parent Deceased
_____ Living together
_____ Separated
_____ Divorced
_____ Mother remarried
_____ Father remarried
_____ Other

Dates of Marriage: From _____ To _____ Number of years _____

Dates of other Marriages: From _____ To _____ Number of years _____

CHILDREN: Please list all children living and deceased (including patient) in the order of their birth:

NAME	AGE	BIRTHDATE	SEX	SCHOOL	GRADE

Other person living in the home? Yes _____ No _____

If yes: Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Logan Health Behavioral Health
200 Heritage Way • Kalispell, MT 59901

ADOLESCENT DEVELOPMENTAL HISTORY MENTAL HEALTH UNIT

8765-022 7/21

FAMILY HISTORY OF:
****Please state relationship to patient**

ASD: _____

_____

ADHD: _____

_____

Bipolar: _____

_____

Anxiety: _____

_____

Suicide: _____

_____

Alcoholism: _____

_____

Depression: _____

_____

Drug Abuse: _____

_____

Attempted Suicide: _____

_____

Intellectual Disabilities: _____

_____

1. What are your expectations of this hospitalization? _____

_____

_____

_____

2. Identify patient and family strengths that will be helpful in treatment? _____

_____

_____

_____

3. Was there any difficulty during the patient's birth? If so, please explain:_____

_____

_____

4. Did the patient's mother have any problems during pregnancy? If so, please explain: _____

_____

_____

_____

5. Has the patient shown any slow development in growth, walking, talking, learning, playing, etc.? If so, please describe:

_____

_____

_____

6. If there was slowing in the patient's development, describe any factors that you feel may be the cause; such as childhood disease, hospitalizations, upsetting experiences, and problems in the home or with other family members.

_____

_____

7. If the patient has ever received medication on a regular basis, what was it called and why was it prescribed? _____

_____

_____

_____

8. Does the patient have any allergies? Please identify what they are, and possible reactions. _____

_____

_____

9. Has the patient ever been involved in a serious trauma (i.e. car accident, death of family member)? If so, please identify what the treatment was and how the patient dealt with it. _____

_____

_____

10. Has the patient experienced any types of abuse (i.e. physical, sexual, emotional)? _____

_____

_____

_____

11. Does the patient have a history of drug or alcohol use? _____

_____

_____

_____

12. Do you have any concerns for an eating disorder? If so, please explain: _____

_____

_____

_____

_____

_____

13. Female patient: When was her first menstrual period? _____ Identify any difficulties she has had or is having (i.e. cramping, nausea, headaches). Has the patient had an abortion? If so, when? _____

_____

_____

_____

_____

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie,"cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____ Total number of questions scored 2 or 3 in questions 10–18:_____ Total Symptom Score for questions 1–18: _____ Total number of questions scored 2 or 3 in questions 19–26:_____

Total number of questions scored 2 or 3 in questions 27–40:_____

Total number of questions scored 2 or 3 in questions 41–47:_____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score:_____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

PATIENT RIGHTS

1. The right to be free from discrimination
2. The right to receive a statement of your rights and have rights posted
3. The right to have confidential records maintained
4. The right of access to a patient advocate or lawyer
5. The right to be treated with dignity
6. The right to privacy
7. The right to freedom from unnecessary camera surveillance
8. The right to freedom from unnecessary searches
9. The right to a humane and safe environment
10. The right to comfort and safety
11. The right to receive visitors
12. The right to private telephone conversations
13. The right to send and receive mail
14. The right to wear your own clothing
15. The right to personal hygiene and grooming
16. The right to read books and materials of your own choice
17. The right to practice your religion
18. The right to an adequate diet
19. The right not to be photographed except for confidential identification unless you want to be
20. The right to regular exercise
21. The right to appropriate treatment
22. The right to prompt and adequate medical treatment
23. The right to a treatment plan
24. The right to participate in planning your own treatment
25. The right to be free from unnecessary restraint and isolation
26. The right to be free from abuse and neglect
27. The right to appropriate referral upon discharge
28. The right to freedom from unnecessary or excessive medication
29. The right to necessary informed consent
30. The right to file complaints
31. The right to an advanced medical directive

Full explanations of your rights are available to you at the nursing station.

8765-176 6/14

Logan Health Behavioral Health
Adolescent Programming Schedule 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:20–Wakeup	7:20–Wakeup	7:20–Wakeup	7:20–Wakeup	7:20–Wakeup	7:45–Wakeup	7:45–Wakeup
7:30–Breakfast	7:30–Breakfast	7:30–Breakfast	7:30–Breakfast	7:30–Breakfast	8:00–Breakfast	8:00–Breakfast
8:00–Shower, Chores & Token Economy	8:00–Shower, Chores & Token Economy	8:00–Shower, Chores & Token Economy	8:00–Shower, Chores & Token Economy	8:00–Shower, Chores & Token Economy	8:30–Shower, Chores & Token Economy	8:30–Shower, Chores & Token Economy
9:00–Rounds & Goals	9:00–Goals	9:00–Rounds & Goals	9:00–Goals/9:15 Med Ed	9:00–Goals	9:15–Goals	9:15–Goals
10:00–Recreation Therapy	10:00–Recreation Therapy	10:00–Recreation Therapy	10:00–Recreation Therapy	10:00–Recreation Therapy	10:00–Gym/Structured Activity	10:00– Gym/Structured Activity
11:00–Life Skills	11:00–Life Skills	11:00–Life Skills	11:00–Life Skills	11:00–Life Skills	11:00–Visiting	11:00–Visiting
12:00–Lunch	12:00–Lunch	12:00–Lunch	12:00–Lunch	12:00–Lunch	12:00–Lunch	12:00–Lunch
12:30–Room Time	12:30–Room Time	12:30–Room Time	12:30–Room Time	12:30–Room Time	12:30–Room Time	12:30–Room Time
1:00–Process Group	1:00–Process Group	1:00–Process Group	1:00–Process Group	1:00–Process Group	1:00–Process Group	1:00–Process Group
2:00–Pet Therapy/ Wellness Group	2:00–Addictions Group	2:00–Assignments	2:00—Addictions Group	2:00–Assignments	2:00–Assignments	2:00–Assignments
2:30–Assignments		2:30–Gym/Structured Activity		2:30–Gym/Structured Activity	2:30–Gym/Structured Activity	2:30–Gym/Structured Activity
3:00–Reading in Room/Bed-Side Report	3:00–Reading in Room/Bed-Side Report	3:00–Reading in Room/Bed-Side Report	3:00–Reading in Room/Bed-Side Report	3:00–Reading in Room/Bed-Side Report	3:00–Reading in Room/Bed-Side Report	3:00–Reading in Room/Bed-Side Report
4:00–Recovery Planning *B	4:00– Recovery Planning *C	4:00–Recovery Planning *D	4:00–Recovery Planning *E	4:00–Recovery Planning *F	4:00– Recovery Planning *G	4:00– Recovery Planning *A
4:45–Dinner	4:45–Dinner	4:45–Dinner	4:45–Dinner	4:45–Dinner	4:45–Dinner	4:45–Dinner
5:30–Gym	5:30–Gym	5:30–Gym	5:30–Gym	5:30–Gym	5:30–Structured Activity/Journaling	5:30–Structured Activity/Journaling
6:00–Visiting	6:00–Visiting	6:00–Visiting	6:00–Visiting	6:00–Visiting	6:00–Exercise/Structured Activity/Yoga	6:00–Gym
7:00–Post-Visit/Reflections	7:00–Post-Visit/Reflections	7:00–Structured Activity	7:00–Art Therapy (w/Adol Staff)	7:00–Post-Visit/Reflections	7:00–Reflections	7:00– Exercise/Structured Activity/Yoga
7:30-Exercise/Structured Activity/Yoga	7:30-Exercise/Structured Activity/Yoga	8:00–Post-Visit/Reflections	8:00–Post-Visit/Reflections	7:30–Movie/Snack/Daily Points/Meds	7:30–Movie/Snack/Daily Points/Meds	
8:30–Snack/Daily Points/Meds	8:30–Snack/Daily Points/Meds	8:30–Snack/Daily Points/Meds	8:30–Snack/Daily Points/Meds			
9:00–Stress Reduction	9:00–Stress Reduction	9:00–Stress Reduction	9:00–Stress Reduction	9:00–Stress Reduction	9:00–Stress Reduction	9:00–Stress Reduction
9:30–Bedtime	9:30–Bedtime	9:30–Bedtime	9:30–Bedtime	9:30–Bedtime	9:30–Bedtime	9:30–Bedtime
10:00–Lights Out	10:00–Lights Out	10:00–Lights Out	10:00–Lights Out	10:00–Lights Out	10:00–Lights Out	10:00–Lights Out

*Recreational/Exercise Focused Groups *Planning, Education and/or Medication Groups *Addictions Focused Groups * Visiting

**Pet Therapy 1st & 3rd Monday of Month—Wellness Group 2nd Monday of Month

Recovery Planning Curriculum

*Session A: Let's Talk About Wellness. Key concepts of Recovery Planning. (Step 1- p. 96-99)

*Session B: Develop Daily Wellness Plan. (Step 2 – p. 100-101)

*Session C: Learning to Cope & Coping with triggers. (Step 2 p. 102- 103)

*Session D: Triggers, triggers action planning and early warning signs. (Step 3 – p. 103-104)

*Session E: Putting the Plan into action (Step 4- p. 104-105)

*Session F: Safety Planning: (Step 5 - p.106-107)

*Session G: Refining the Plan. (Step 6-p. 109-115)

Education Group Topics/Ideas

- Sympathetic/Para-sympathetic nervous system response to stressors/triggers
- Family roles
- Goal setting (short and long-term)
- Financial responsibility (budgeting/managing money)
- School concerns (bullying, interpersonal relationships, organization, handling stress)
- Social-skills building
- Hygiene
- Resume building

Life Skills Approved Lesson Plans:

- Anger
- Anxiety
- Body Movement/Exercise
- Boundaries
- Bullying
- Communication
- Defense Mechanisms
- Depression
- Distorted Thinking
- Emotions
- Mindfulness
- Problem Solving-Decision Making
- Responsibility
- Self-Reflection
- Wellness and Crisis

Logan Health Behavioral Health Visitation

Adults	Adolescents
Monday - Friday	Monday - Friday
9:00 am - 10:00 am	6:00 pm - 7:00 pm
Saturday - Sunday	Saturday - Sunday
1:00 pm - 2:00 pm	11:00 am - 12:00 pm
Phone Calls 406-756-3950	Phone Calls 406-751-7174 or 406-751-7695 6:00 pm - 7:00 pm Weekdays 11:00 am - 12:00 pm Weekends

*When calling during these times, if the phone is busy, please try again in 5-10 minutes.

* Persons **17 and under** are **not permitted** to visit the unit.

* Accommodations will need to be reviewed with the Treatment Team.

Visitor Expectations

1. All visitors must sign in at the front office.
2. To accommodate all families, the number of visitors at one time is limited to 2.
3. Please do not bring personal belongings, e.g. purses, backpacks, cell phones, radios, etc.
4. Anything brought for patients must be checked in at the front office.
5. Please observe any patient restrictions.
6. Anyone who is suspected of being under the influence of alcohol or drugs will be asked to leave.
7. Food is not allowed to be brought in for any reason.
8. Please be off the unit as soon as the visitation time is up for the patient you are visiting.
9. Visitors will not be allowed to smoke on the premises.
10. Visiting is permitted in camera monitored patient rooms at the discretion of the treatment team.

8765-219 7/21; 3/22; 5/22

To all family members and significant others:

For the safety of all clients and staff, the items listed below are **not allowed** to be in the client's possession upon arrival on the unit. These items are returned to the client upon his/her discharge. Some items may be approved for use when appropriate. Adolescents have the ability to earn privileges such as wearing make-up or wearing a hat.

You are one of the most important factors to the patient at the time of hospitalization. The treatment team must have your backing, support, and availability if progress is to be made. If you have feelings or significant information concerning the patient and his/her illness, you are encouraged to share them with the staff.
Visiting privileges for our patients are based on their treatment progress. Visiting schedules may be altered or limited due to individual treatment needs. Visitors are expected to respect the confidentiality of patients they meet or see. They are also expected to comply with Logan Health Behavioral Health visitor expectations.

No Outside Food or Drink

Hygiene/Grooming

- Products with alcohol in them, i.e. acne products
- Safety razors
- Nail files, clippers, or any metal items
- Glass, i.e. make-up containers
- Toothpicks, floss picks
- Aerosol cans
- Nail polish, remover
- Hair coloring products
- Hair dryers, curling irons, flat irons
- Body sprays

Clothing/Personal Items

- Any clothing deemed inappropriate
- Tank tops only as undershirts
- Swimsuits
- Baseball caps, beanies, bandannas
- Belts, ties, suspenders
- Wire or plastic clothes hangers
- Shoelaces, clothes with drawstrings
- Wallets, handbags
- Money, credit cards, checkbooks, IDs
- Make-up, make-up tools
- Jewelry (specific items may be approved by admitting nurse)

Miscellaneous

- Alcohol
- Cigarettes
- Chew
- Illicit drugs
- Medical marijuana
- Prescription medications
- Over-the-counter medications
- Home remedies
- Plastic bags of any size
- Balloons
- Flowers are allowed only in plastic vases, no long ribbons or keys
- Movies, CDs
- Electronic devices, i.e. cell phones, iPods
- Pencil sharpeners
- Glass or metal containers
- Matches, lighters
- Knives, weapons of any kind
- Scissors, sharp items

Logan Health Behavioral Health

(406) 756-3950 or Toll Free (800) 756-3950

FEDERAL TRUTH IN LENDING ACT NOTIFICATION

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

1. If you want to preserve your rights under the Act, here's what to do if you think your bill is wrong or if you need more information about an item on your bill:

a. Do not write on the bill. On a separate sheet of paper write the following:
   i. Your name and account number.
   ii. A description of the error and an explanation, as best you can, of why you believe it is an error. If you only need more information, please explain the item you are not sure about. Do not send in your copy of the itemized statement or other documents unless you have a duplicate copy for your records.
   iii. The dollar amount of the suspected error.
   iv. Any other information (such as your address) which you think will help us identify you or the reason for your complaint or inquiry.

b. Send your billing error notice to the address listed on your billing statement. Mail it as soon as you can, but in any case early enough to reach us within 60 days after the bill was mailed to you. YOU MAY TELEPHONE YOUR INQUIRY, BUT DOING SO WILL NOT PRESERVE YOUR RIGHTS UNDER THIS LAW NOR OBLIGATE US TO FOLLOW THE OUTLINED PROCEDURES.

2. We must acknowledge all letters pointing out possible errors within 30 days of receipt unless we are able to correct your bill within 30 days. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill to be correct. Once we have examined the bill, we have no further obligation to you even though you still believe there is an error, except as provided in paragraph 4, below.

3. After we have been notified, in writing, neither we nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount in dispute; but periodic statements may be sent to you. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. However, you remain obligated to pay the part of your bill not in dispute.

4. If our explanation does not satisfy you and you notify us in writing within 10 days after you receive our explanation that you still refuse to pay the disputed amount, we may report you to credit bureaus and other creditors and may pursue regular collection procedures. But we must also report that you think you do not owe the money, and we must let you know to whom such reports were made. Once the matter has been settled between you and us, we must notify those to whom we reported you as delinquent of the subsequent resolution.

DISCLOSURES REQUIRED BY FEDERAL LAW

Your account is subject to the following terms and conditions:

1. If an account is referred for collection, you shall pay all collection and court costs, including a reasonable attorney's fee. Otherwise than herein and above specified, you shall incur no additional charges to your account.
2. No security interest in any property is retained or acquired for purposes of securing payment of any credit extended on your account, except: (1) any security interest acquired by virtue of Montana's Liens of Certain Health Care Providers law, MCA Title 71, Ch. 3, Part 11, and (2) any security interest in property retained by the hospital to secure payment of your account.

YOUR RIGHTS AND RESPONSIBILITIES

As a patient, you have certain rights and responsibilities. We encourage you to speak openly with your healthcare team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care.

Your Rights: Decision-making and Communication

You have the right...

- To designate a health care proxy to assist you with making medical decisions.
- To discuss ethical issues surrounding your care.
- To be told about your diagnosis, benefits, risks, and outcomes of treatment.
- To know the name, role, and specialty of everyone providing your care.
- To participate in decisions about your care and your treatment, including the right to refuse treatment.
- To receive communication in a language and manner that you can understand.
- To receive information regarding your discharge, transfer, or follow-up care.

Your Rights: Financial Matters

You have the right...

- To receive detailed information about your hospital and physician charges.
- To know if your doctor has a conflict of interest as it relates to your care.
- To request and receive information about financial assistance or free care
-

Your Rights: Care and Treatment

You have the right...

- To receive considerate, respectful, and compassionate care regardless of your age, gender, race, national origin, religion, or any other category protected by law.
- To receive care in a safe environment.
- To privacy and confidentiality in care discussions, exams, and treatments.
- To be free from restraints and seclusion that are not medically required.
- To access protective and advocacy services in cases of abuse or neglect.
- To give or refuse consent for recordings (audio or visual) used for purposes other than identification, diagnosis, or treatment.
- To voice your concerns about the care you receive.

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Your Rights: Personal Matters

You have the right…

- To spiritual services in a manner respective of your personal beliefs.
- To appoint someone to make health care decisions for you if you are unable.
- To medical confidentiality as provided under the law.
- To refuse to participate in medical research studies.

Your Responsibilities

You have the responsibility...

- To provide complete and accurate information about your medical history. To ask questions or acknowledge when you do not understand the treatment course or care decisions. You are responsible for outcomes if you do not follow the treatment plan.
- To follow instructions and the rules of the hospital, which are designed to keep you, other patients, and visitors safe and comfortable.
- To treat hospital staff, other patients, and visitors with courtesy and respect.
- To be considerate of other patients and their property. This includes helping to control noise.
- To provide complete and accurate information about your health insurance coverage and to pay your bills promptly.
- To keep appointments and, when unable to do so, to notify the responsible practitioner or healthcare facility.
- To provide a copy of Advance Directives, if applicable.

LOGAN
HEALTH

JOINT NOTICE OF PRIVACY PRACTICES

LOGAN HEALTH

Effective Date: March 22, 2021

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

Your Rights

The following is a summary of your rights. A more detailed description of each right is included in this document.

- Get a copy of your paper or electronic medical record
- Request correction of your paper or electronic medical rec
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your informat
- Get a copy of this Notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that Logan Health uses and shares your Medical Information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include your information in a hospital directory
- Provide mental health care
- Market our services
- Raise funds

Our Uses and Disclosures

Logan Health may use and share your Medical Information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

If you have any questions or would like to ask for one of the services outlined in this Notice, please contact the Logan Health Health Information Management Office by phone at (406) 752-1740 or in writing to Logan Health, Health Information Management, 310 Sunnyview Lane, Kalispell, MT 59901.

Your Rights and Choices

When it comes to your medical information, you have certain rights. This section explains your rights and Logan Health's responsibilities to help you.

Get a paper or electronic copy —You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. If you would like, we also can send this information in either paper or electronic form to another person you identify in your request. We will provide a copy or a summary of your medical information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask Logan Health to correct your medical record — If you feel that medical information we have about you is incorrect or incomplete, you may ask us to correct the information. We may say no to your request but we will tell you why in writing within 60 days.

Request Confidential Communications — You have the right to ask that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will say yes to all reasonable requests.

Ask Logan Health to limit what we share or use — You can ask us not to use or share certain medical information for treatment, payment, or Logan Health's operations. We are not required to agree to your request, and we may say "no" if it would be harmful or compromise your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. A restriction is not in effect until you receive written notice that we are able to approve your request.

Get a list of those with whom we've shared your information — You can ask for a list (accounting) of the times we've shared your medical information for six years prior to the date you ask, who we shared it with, and why. Please let us know what form you want the list (e.g., on paper, electronically). We will include all we have shared your information with except for those about treatment, payment, to run our organization, and certain other ways we share (such as any you asked us to make). We will provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a Paper Copy of This Notice —You can ask for a copy of this Notice at any time, even if you have agreed to receive this Notice electronically. You may also get a copy of this Notice on our web site at www.kalispellregional.org, or by contacting the Logan Health Corporate Compliance Office listed above on this Notice.

Photographs — Medical photographs or other video images may be taken before, during, or after a procedure or treatment to be used as part of the medical record to document treatment. Sometimes where the patient cannot be identified, images could be used for other purposes, including but not limited to, medical education, patient education, or publications.

File a complaint if you feel your privacy rights have been violated —

- You can call the Logan Health Corporate Compliance Office at (833) 594-0321 with questions. All complaints need to be submitted in writing to Logan Health, Corporate Compliance Office, 310 Sunnyview Lane, Kalispell, MT 59901 or in writing by email at complianceoffice@logan.org.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
  You will not be retaliated against for filing a complaint.

Facility Directories and Religious Preferences — Unless you tell us not to, we will include the following information in any facility directory: your name, location in the facility, and your condition stated in general terms that does not communicate any specific medical information about you. We may also list any religious preference you tell us in directories provided to clergy. If you choose to not be in the facility directory, you will not be able to have visitors, flower deliveries or other services like this.

Our Uses and Disclosures

We typically use or share your medical information in the following ways:

To treat you — We can use your Medical Information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To bill for your services — We can use and share your medical 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 your services.

To run our organization — We can use and share your Medical Information to run our practice, improve your care, and contact you when necessary. All of our locations work closely together to improve health care operations across the Logan Health system, and we may use Medical Information for those activities. We may share your Medical Information to our business associates that help us with our administrative and other functions, another health care provider who has treated you, or to your insurance company. This may be done when the information is needed for health care operations of the health care provider or the insurance company, such as quality improvement activities, evaluations of health care professionals, and state and federal regulatory reviews.

Example: We use medical information about you to manage your treatment and services.

How else can Logan Health use or share your Medical Information?

Family and Friends — Unless you ask us not to, we may share your Medical Information that can help a family member, relative, close personal friend, or any other person identified by you who is a part of your health care or payment related to

your health care make decisions and stay informed. We may also tell your family or friends your general condition and that you are in the hospital. If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Fundraising Activities — We may share some of your information with the Logan Health Foundation to respectfully contact you for gift support using information such as your name and address. For example, we use charitable gifts to fund heart and cancer care programs and needed charity care. If you would like to opt out of receiving fundraising communications from the Logan Health Foundation, you may do so by contacting the Foundation via:

- telephone (406) 751-6930
- email —foundation@logan.org; or
- written request to Logan Health Foundation, 310 Sunnyview Lane, Kalispell, MT 59901

Help with Public Health and Safety Issues —We may share your Medical Information for public health activities. These activities generally include the following:

- Prevent or control disease, injury or disability;
- Reporting births and deaths;
- Reporting child abuse or neglect;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products they may be using;
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

For Research —We can use or share your information for health research. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. We will ask for your written permission to participate in a research study or you may refuse to participate.

For Workers' Compensation — We may share your Medical Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Avoid a Serious Threat to Health or Safety — We may use and share your Medical Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. Disclosures regarding infectious diseases must comply with applicable state laws limiting the disclosure of patient identity and related information.

Deceased Individual — Deceased Individual — As allowed by law, we may share the Medical Information of a deceased individual to family members, relatives or any other persons who are authorized by law to act for the deceased individual.

Health Information Exchange — We may share information that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges ("HIEs") in which we participate. For example, information about your past medical care and current medical conditions and medications can be available to us or to your non-KRH primary care physician or hospital, if they participate in the HIE. Exchange of medical information can provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. If you do not want your/your child's data sent to an HIE, please check the box on the acknowledgement of the Notice of Privacy Practices ("Notice").

Immunization Data with the Montana DPHHS Immunization Information System ("IIS") — The Montana Department of Public Health and Human Services (DPHHS) maintain a confidential, computerized system that collects makes the information usable. DPHHS has requested that we seek your consent to share your/your child's immunization data with them. If you do not want your/your child's immunization data, please check the box on the acknowledgement of the Notice.

Inmates — If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may share your Medical Information with the correctional institution or law enforcement official. Sharing would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Marketing — Logan Health does not sell or rent our patients' names or addresses to any organization outside of Logan Health.

Medical Examiner or Funeral Director— We can share medical information with a coroner, medical examiner, or funeral director when an individual dies.

Military and Veterans — If you are a member of the armed forces, we may share your Medical Information as required by military command authorities. We may also share medical information about foreign military personnel to the appropriate foreign military personnel.

National Security & Intelligence — By law, we may share your Medical Information to authorized federal officials for intelligence, counterintelligence, or other national security activities.

Protective Services for the President and Others — We may share your Medical Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Organ and Tissue Donation Requests — Logan Health may share medical information about you with organ procurement organizations.

Schools — We may share Medical Information to a school about an individual who is a student or prospective student of the school if the Medical Information is limited to proof of immunization, the school is required by state or other law to have that proof of immunization prior to admitting the individual, and we obtain and document the agreement to the disclosure from either the individual's parent/guardian or from the individual if the individual is an adult or emancipated minor.

Telehealth Services — We may use telehealth technology to connect you with a provider, and such consultations may be conducted by videoconferencing, video images, high quality still images and/or by telephone conference. Your Medical Information may be shared with 3rd party companies to gain access to audio, video, and/or photography consultation services as necessary for providing quality health care services via telehealth technology, which, in some cases, may be facilitated with the assistance of a facilitator who is not affiliated with or employed by Logan Health. You will have the chance to choose not to be seen by a doctor by video or phone at the time you register for your visit.

To Comply with the Law — We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it requests to see that we're complying with federal privacy law.

To Respond to Lawsuits and Legal Actions —We may share medical information about you in response to a court or administrative order, or in response to a subpoena.

Your Choices

Confidentiality - We won't share your information unless you give us written permission for (1) marketing purposes, or (2) sharing of psychotherapy notes.

For Mental Health Treatment— We may only share your mental medical information with professionals for treatment, to get payment for services provided, or as otherwise required by state law.

Drug or Alcohol Abuse Treatment — Certain Logan Health facilities, units, and staff specialize in providing substance use disorder treatment (Programs). The confidentiality of substance use disorder patient records maintained by these Programs is protected by special federal law and regulations, in addition to HIPAA. Generally, such a Program may not say to a person outside the Program that a patient attends the Program, or share any information identifying a patient as having or having had a substance use disorder unless:

- The patient consents in writing;
- The disclosure is allowed by a court order; or
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Who is Covered by this Notice

To help serve your health care needs, the following organizations are a part of our Organized Health Care Arrangement, which allows them to: (1) share your Medical Information with each other for the purposes of treatment, payment, or health care operations, and (2) requires them to follow the terms of this Notice:

- Kalispell Regional Healthcare System
- Kalispell Regional Medical Center ("**KRMC**"), including its physician clinics, listed below
- KRMC doing business as Home Options
- KRMC doing business as Pathways Treatment Center
- KRMC doing business as Polson Health Outpatient Center
- KRMC doing business as Outpatient Surgery Center
- The Health Center, including its physician clinics, listed below
- Applied Health Services doing business as Kalispell Medical Equipment
- Northwest Horizons doing business as Brendan House
- Northwest Orthopedics & Sports Medicine
- The Summit Medical Fitness Center

Kalispell Regional Medical Center currently includes, but is not limited to: Bass Breast Center; Big Sky Family Medicine;

Bigfork Medical Clinic; Diabetes Care and Prevention Center; Digestive Health Institute of Montana; Employee Health & Wellness; Eureka Specialty Services; Family Born Maternity and Women's Health; Family Health Care; Flathead Valley Orthopedics Clinic; Geriatric and Supportive Care; Glacier View Plastic Surgery; Greater Flathead Renal; Kalispell Medical Office and Bone Health; Kalispell Regional Rheumatology Specialists; Kalispell Regional Urology Specialists; Kalispell Regional Healthcare Sleep Center; Kalispell Regional Healthcare Surgical Specialists; The Montana Center for Wellness and Pain Management; Montana Children's; Montana Children's Specialists, Montana Children's Maternal-Fetal Medicine; Neuroscience & Spine Institute; Department of Neurological Surgery & Department of Neurology; Department of Physical
Medicine and Rehab; The Newman Center; Northwest Center for Specialty Oncology Care: Division of Surgical Oncology & Division of Therapeutic Gastrointestinal Endoscopy; Kalispell Regional Behavioral Health; Northwest Family Medicine; Northwest Hospitalists; Northwest Montana Radiation Oncology; Northwest Montana Surgical Associates; Northwest Oncology and Hematology; Northwest Orthopedics and Sports Medicine; Northwest Specialists; Northwest Specialty Clinic Whitefish; Northwest Women's Health Care; Outpatient Surgery Center; Pathways Treatment Center; Pediatric Endocrinology and Diabetes Center; Peri & Neonatal Services at KRMC; Polson Health; Rocky Mountain Heart and Lung: Cardiology, Pulmonology, Electrophysiology; Sunny View Pediatrics; Westshore Medical Clinic; Woodland Clinic; Wound and Ostomy Center.

As we are transitioning to our new brand "Logan Health," the above entities will become known as the following (likewise covered by this Notice):

- Logan Health
- Logan Health Medical Center ("LHMC"), including its provider clinics, listed below
- LHMC doing business as Logan Health Home Care & Hospice
- LHMC doing business as Logan Health Behavioral Health
- LHMC doing business as Logan Health Surgery Center - Polson
- LHMC doing business as Logan Health Surgery Center - Kalispell
- Applied Health Services doing business as Logan Health Medical Equipment
- Northwest Horizons doing business as Logan Health Brendan House
- Logan Health Medical Fitness Center

Logan Health Medical Center currently includes, but is not limited to: Logan Health Breast Center; Logan Health Primary Care;
Logan Health Diabetes Education & Prevention; Logan Health Digestive Center; Logan Health Employee Health & Wellness; Logan Health Women's Care; Logan Health Orthopedics & Sports Medicine; Logan Health Palliative Medicine; Logan Health Plastic & Reconstructive Surgery; Logan Health Nephrology, Logan Health Surgical Clinic; Logan Health Wellness & Pain Management; Logan Health Maternal Fetal Medicine; Logan Health Neuroscience & Spine; Logan Health Newman Center; Logan Health Community Behavioral Health; Logan Health Hospitalists; Logan Health Radiation Oncology; Logan Health Hematology & Oncology; Logan Health Endocrinology & Infectious Disease; Logan Health Specialty Care-Whitefish; Logan Health Specialty Care-Columbia Falls; Logan Health Children's Specialists; Logan Health Peri & Neonatal Services; Logan Health Heart & Lung; Logan Health Children's Primary Care; Logan Health Wound Care; Logan Health Urology; Logan Health Rheumatology; Logan Health Children's; Logan Health Specialty Care-Eureka, Polson, Great Falls, Helena, Bozeman, Libby, Missoula; Logan Health Sleep Lab.

The above organizations are referred to "we," "our," or "us" and include:

- Any health care professional authorized to access or enter information into your medical record;
- All departments of the organizations covered by this Notice;
- Any member of a volunteer group we allow to help you; and
- All of our employees, staff, and other personnel.

Our Legal Duty Regarding Your Medical Information

We are committed to protecting your medical information ("Medical Information"). Medical Information covered by this Notice is information: (1) that identifies you or could be used to identify you; (2) that we collect from you or that we create or receive; and (3) that relates to your past, present or future physical or mental health condition, including health care services provided to you and past, present, or future payment for such health care services.

When you are treated at any of our facilities, we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with applicable legal requirements. This Notice applies to your Medical Information that is created or received by us. It is possible that your doctor may also create medical information at other

hospitals or medical facilities. Those facilities may have different policies or notices regarding their use and disclosure of your medical information created by your doctor while at that facility.

This Notice informs you of: (1) our legal obligations regarding your Medical Information, (2) how we may use and share your Medical Information, and (3) what your rights are regarding your Medical Information.

The law requires us to:

- Make sure that your Medical Information is kept private as explained in this Notice;
- Give you this Notice of our legal duties and privacy practices regarding your Medical Information;
- Follow the terms of the Notice in effect; and
- Notify you of any unauthorized disclosure of your Medical Information.

Contact Information

If you have any questions about this Notice, please contact the Logan Health Corporate Compliance Office at (833) 594021 or in writing at Logan Health, Compliance Office, 310 Sunnyview Lane, Kalispell, MT 59901.

Changes to the Terms of This Notice

Logan Health 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, in our offices and clinics, and on our web site at www.logan.org.

Other Uses of Medical Information

Other uses and disclosures of your Medical Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or share your Medical Information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or share your Medical Information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Information Regarding Advance Directives

LOGAN HEALTH

Policy:

It is the policy of Logan Health to inform all persons of their rights to make decisions about their treatment, including the right to accept or refuse treatment and the right to formulate an Advance Directive.

Patient care shall not be a condition of, nor shall a patient be discriminated against in any way, because of the presence or absence of an Advance Directive.

Logan Health shall make every effort to comply with the Patient Self Determination Act and the Montana Rights of Terminally Ill Act, in the provision of care to the patients whom we serve.

Definitions:

1. Physician: An individual licensed to practice medicine under Title 37, Chapter 3, of the Montana State Laws.

2. Attending physician: The physician selected by, or assigned to the patient, and who has primary responsibility for the treatment and care of the patient.

3. Declaration: A document executed in accordance with the Patient Self Determination Act and the Montana Rights of the Terminally Ill Act.

4. Life sustaining treatment: Any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process.

5. Qualified patient: A patient 18 years of age or older who has executed a declaration in accordance with this chapter and who has been determined by the attending physician to be in a terminal condition.

6. Terminal condition: An incurable or irreversible condition, that without the administration of life sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

Questions and Answers regarding Advance Directives:

1. Q. What is an Advance Directive?
   A. An Advance Directive is a document that instructs your physician regarding your wishes to accept or refuse life sustaining treatment if you are in a terminal condition and are unable to express your wishes at the time.
2. Q. Who can create an Advance Directive?
   A. An individual of sound mind and 18 years of age or older may execute at any time a declaration governing the withholding or withdrawal of life sustaining treatment (MCA 50-9-103). The person making the declaration may designate the attending physician, or another individual of sound mind and 18 years of age or older, to make decisions governing the withholding or withdrawal of life sustaining treatment.

3. Q. When does an Advance Directive become operative?
   A. An Advance Directive becomes operative when:
      i. it is communicated to the attending physician; and
      ii. the person making the declaration is determined by the attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life sustaining treatment.

4. Q. What happens if my physician does not wish to comply with my Advance Directive?
    A. If the attending physician is unwilling to comply with the patient's Advance Medical Directive, the physician shall take all reasonable steps as promptly as possible to transfer care of the declarant to another physician or healthcare provider who is willing to do so.
    B. If the other health care provider is unwilling to comply with the patient's Advance Medical Directive, the other healthcare provider shall take all reasonable steps as promptly as possible to transfer care of the declarant to another health care provider who is willing to do so.

5. Q. May I revoke an Advance Directive already made?
    A. Yes. A declarant may revoke a declaration at any time and in any manner, without regard to mental or physical condition. A revocation is effective upon its communication to the attending physician or other health care provider by the declarant or a witness to the revocation.

6. Q. If my Advance Directive was made in another state, can it be honored in Montana?
    A. A declaration executed in a manner substantially similar to the requirements of the Montana Rights of the Terminally Ill Act, but done in another state, and in compliance with the laws of the state, is effective for the purposes of Montana law.

7. Q. What are some common forms of Advance Directives?
    A. Common forms of Advance Directives are:
    B. a Declaration to Physician;
    C. a Declaration to Individual;
    D. a Durable Power of Attorney;
    E. a Judicial Appointment;
    F. a Living Will Protocol as defined in (MCA 50-9-102).

8. Q. How can I create an Advance Directive?
    A. An individual who is eligible to complete an Advance Directive should discuss the intended Advance
    B. Directive with his/her personal physician. The Advance Directive should be communicated to the attending physician in writing and in the appropriate form.

9. Q. If I am a patient of Logan Health and have other questions regarding Advance Directives, whom should I contact?
    A. Please discuss an Advance Directive with your physician, or request from your nurse that a member of the hospital Case Management Department provide you with additional information.