

# 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 DPHHS, 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 Health website 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**



**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 "in 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.

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

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

**Date:**

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# 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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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

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**Primary Emergency Contact Name:** \_\_\_\_\_  
Last First

**Relationship:** \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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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

**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** \_\_\_\_\_ Other \_\_\_\_\_  
 \_\_\_\_\_ Psychiatric Evaluation/Consult \_\_\_\_\_ IM H&P/Consult  
**Please Initial:** \_\_\_\_\_ 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 \_\_\_\_\_



**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** \_\_\_\_\_ Other \_\_\_\_\_  
 \_\_\_\_\_ Psychiatric Evaluation/Consult \_\_\_\_\_ IM H&P/Consult  
**Please Initial:** \_\_\_\_\_ Discharge Summary \_\_\_\_\_ Progress Notes \_\_\_\_\_ ER Report  
 \_\_\_\_\_ Medications \_\_\_\_\_ Laboratory Reports  
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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 \_\_\_\_\_

# 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.**

**Logan Health Behavioral Health  
Adult Programming Schedule 2023**

Monday	Wednesday	Thursday	Friday	Saturday	Sunday
Dayroom Open	5:30–Dayroom Open	5:30–Dayroom Open	5:30–Dayroom Open	5:30–Dayroom Open	5:30–Dayroom Open
Phone On	7:00–Phone On	7:00–Phone On	7:00–Phone On	7:00–Phone On	7:00–Phone On
Breakfast	8:00–Breakfast	8:00–Breakfast	8:00–Breakfast	8:30–Breakfast	8:30–Breakfast
Medications/Visiting	9:00– Medications/Visiting	9:00– Medications/Visiting	9:00– Medications/Visiting	9:00–Medications <b>AA-Conference Room</b>	9:00–Medications
Process	10:00–Process Group	10:00–Process Group	10:00–Process Group	10:15–Process Group	10:15–Process Group
Recreational	11:15–Recreational Therapy	11:15–Recreational Therapy	11:15–Recreational Therapy		
Lunch	12:30–Lunch	12:30–Lunch	12:30–Lunch	12:30–Lunch	12:30–Lunch
Addiction	1:15–Addictions Group	2:30–LHBH 101 (Pathways 101)	1:15–Addictions Group	1:00–Visiting	1:00–Visiting
Life Skills	2:30–Life Skills		2:30–Life Skills	2:00–Gym/Patio	2:00–Gym/Patio
Gym/Patio	4:00–Gym/Patio	4:00–Gym/Patio	4:00–Gym/Patio	4:00–Big Book	4:00–Big Book
Dinner	5:15–Dinner	5:15–Dinner	5:15–Dinner	5:15–Dinner	5:15–Dinner
Recovery Planning D*	6:00–Recovery Planning D*	6:00–Recovery Planning E*	6:00–Recovery Planning F*	6:00–Recovery Planning G*	6:00–Recovery Planning A*
					7:00–NA-Conference Room
Reflections	9:00–Reflections	9:00–Reflections	9:00–Reflections	9:00–Reflections	9:00–Reflections
Snack Medications	Snack Medications	Snack Medications	Snack Medications	Snack Medications	Snack Medications
Dayroom	11:00–Dayroom	11:00–Dayroom Closed	12:00–Dayroom	12:00–Dayroom	11:00–Dayroom

## **\*Recovery Curriculum:**

Session A: Key concepts of Recovery Planning (Treatment Goals, Daily Reflections, Overview; p 15-28)

Session B: Identify personalized wellness strategies. Engage in exercises to enhance self-esteem, build competence, and explore benefits of peer support (Developing a Wellness Toolbox, p 29-31)

Session C: Daily maintenance plan and what I'm like when I'm feeling well. (p 32-33)

Session D: Create daily maintenance plan (simple, inexpensive strategies) to stay emotionally and physically healthy. Create a plan to recognize and responding to symptom triggers (p 34-35)

Session E: Triggers, triggers action planning and early warning signs (p. 36-41)

Session F: Signs and symptoms of feeling much worse (p. 42-44)

Session G: Create plan for post-crisis support and learn how to retool Recovery Plan after a crisis to avoid relapse. (Section 5, p 45-52)

### **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
- Art for Relaxation
- Behavior Problems
- Boundaries
- Bullying
- Communication
- Defense Mechanisms
- Depression
- Distorted Thinking
- Emotions
- Mindfulness

# Logan Health Behavioral Health Visitation

## Adults

Monday - Friday

9:00 am - 10:00 am

Saturday - Sunday

1:00 pm - 2:00 pm

Phone Calls 406-756-3950

## Adolescents

Monday - Friday

6:00 pm - 7:00 pm

Saturday - Sunday

11:00 am - 12:00 pm

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.

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

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## 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.

## Your Rights: Personal Matters

You have the right...

- To spiritual services in a manner respectful 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

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 record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- 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](http://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](mailto: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/](http://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](http://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

### 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 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.