Red River Behavioral Health System

Acknowledgment of Consents for Treatment

I acknowledge that I have been given, have been provided time to read and understand, and been given the opportunity to ask questions pertaining the below detailed consents.

Please initial each box below and sign at the bottom

- ☐ Informed Consent for Treatment
- ☐ Notice of Privacy Practice
- ☐ Conditions of Admission
- ☐ Patient Relations and Patient Rights
- ☐ Patient Confidentiality Contract
- ☐ Financial Agreement
- ☐ Patient's Bill of Rights
- ☐ Telehealth services
- ☐ Notification Advocacy Services

For Adolescent Patients

- ☐ Parent/Guardian Waiver of Claims
- ☐ Authorization for the Exchange of Information with School
- ☐ Letter of Guarantee for Contract with Legal Guardian Regarding Treatment
  (Must complete contact form and provide accurate information)

Signature verifies the patient and or guardian was offered and are aware they can receive a copy of the all consent and release forms.

_____ _____ _____

Patient/Guardian *Date* *Time*

_____

Specify Relation to patient if not signed by the Patient

_____ _____ _____

Witness Signatures *Date* *Time*

Patient Label

Red River Behavioral Health System (RRBHS)
Advance Health Care & Psychiatric Directive Acknowledgement

The undersigned acknowledges the following:

- I have been given written notice of my right to accept or refuse medical treatments and my right to formulate an advance health care directive and or psychiatric advanced directive.
- I understand that I am not required to have an advance health care directive and or psychiatric advanced directive in order to receive medical treatment at RRBHS.
- I understand that the terms of any advance health care directive and or psychiatric advanced directive that I have executed will be followed by RRBHS staff in accordance with RRBHS's scope of services and State law.

Please complete one of the following:

☐ **I have executed an Advance Health Care Directive**

☐ **I have executed a psychiatric advanced directive.** Please indicate where **RRBHS** can obtain a copy from, if a copy hasn't already been provided.

Individual/Facility Name:_____ Phone:_____

Address:_____City:_____State:_____Zip:_____

HUC or RN

Request Date: _____Time:_____Staff Signature: _____

☐ I have not executed an Advance Health Care or Psychiatric Directive, but I'd like to meet with a social worker to receive more information.

HUC or RN

Date/Time Social Work Notified:_____ Staff Signature: _____
Date/Time Information Provided:_____ Social Worker Signature: _____

☐ I have not executed an Advance Health Care or Psychiatric Directive and decline further information.

_____
Patient Name

_____ _____ _____
Patient/Guardian Signature Date Time

_____
Specify Relationship to Patient (if not signed by patient)

_____ _____ _____
Witness Signature Date Time

Patient Label

Red River Behavioral Health System
Authorization to Acknowledge Patient's Presence

Patient Name:_____

I authorize the Red River Behavioral Health System to acknowledge my presence as a patient in this facility to the following individuals (please print):

Individual/Specify relationship	Individual/Specify relationship
Individual/Specify relationship	Individual/Specify relationship
Individual/Specify relationship	Individual/Specify relationship

The purpose of the authorization is to be able to receive phone calls and/or visits from these persons, and is limited to immediate family members. If applicable, your cellphone will be inaccessible during hospital stay. Please document needed phone numbers.

Name/Phone Number	Name/Phone Number
Name/Phone Number	Name/Phone Number

This consent may be revoked at any time except to the extent that action has been taken in reliance on it. This consent, unless previously revoked, expires upon my formal discharge from Red River Behavioral Health System.

Patient Label

Red River Behavioral Health System
Letter of Guarantee
For Contact with Legal Guardian Regarding Treatment

Patient Name:_____ Date of Admission:_____

As a term of admission to the Red River Behavioral Health System (RRBHS), we require a guarantee by the patient's legal guardian that telephone contact with the legal guardian is available twenty-four (24) hours per day, seven (7) days per week during the patient's hospitalization. The purpose of this guarantee is to provide timely treatment, pharmacotherapy (medication management) consideration/approval, and notification of changes in treatment, as recommended by the treating physician. A patient's legal guardian must approve the recommended treatment, including pharmacotherapy.

Please indicate below each legal guardian's name, relationship to patient, telephone number, and address of who will be available as described above throughout the course of the patient's hospitalization at RRBHS.

Failure to comply with this Guarantee
may obstruct the course of treatment and
require the patient's early discharge.

Name(s) of Legal Guardian(s)	Relationship to Patient	Phone Number (available 24 hours/day)	Address, City, State, Zip Code

Patient Label

Authorization for Release of Protected or Privileged Health Information

Patient Name: _____ Date of Birth: _____

Preferred Method of Contact (phone, email, address): _____

I hereby consent to release, disclose, obtain, exchange, and/or share my health information among the following:

FROM:
Facility Address/Fax Info:

Red River Behavioral Health Systems

145144th Ave S Unit A

Grand Forks, ND 58201

Phone/Fax: 701-722-2500 / 701-757-1517

TO:
Specific Facility Address/Fax Info:

_____

_____

_____

_____

_____

General Release:

- ☐ Yes, My current and future treating providers
- ☐ Yes, Family and/or personal representative(s) _____

Information to be Released:

- ☐ Yes, Medical records (medical history, physical exam, consults, admission and discharge summaries)
- ☐ Yes, Mental Health Diagnosis and/or Treatment details (Psychological/Psychiatric/Neuropsychological)
- ☐ Yes, Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
- ☐ Yes, Redisclosure of Alcohol and Drug Abuse Records (including assessments and/or addendums)
- ☐ Yes, HIV/AIDS Test Results and/or Status
- ☐ Yes, Lab/Imaging Reports (please specify): _____
- ☐ Yes, Other: _____

Purpose of Release:

☐ Continuing Care ☐ Personal ☐ Insurance ☐ Other: _____

Method of Disclosure:

☐ Verbal Discussion Only DO NOT RELEASE ANY RECORDS ☐ Fax ☐ Mail ☐ Electronic

By my signature below, I understand and consent to the following:

- My health information is protected by federal (HIPAA 45 CFR, 42 CFR Part 2) and state laws and regulations, and disclosure is allowed only with my authorization, except in limited circumstances described in the facility's Notice of Privacy Practices.
- The facility releasing the information cannot control how the recipient uses or shares the information and cannot prevent further release by the recipient.
- I understand releases pursuant to this authorization will identify me as receiving services at this facility - My consent is voluntary, and I may revoke this authorization at any time by giving written notice to the facility, except to the extent that action has already been taken in reliance upon it.
- I allow Meridian owned or affiliated programs to continue to use this release upon transfer of my care to them. Unless revoked earlier or otherwise indicated, this authorization will expire one (1) year from the date of signing.
    - The facility may charge a per page copy fee.
- A fax of photocopy that has not been altered may be considered as valid as the original

NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Patient or Patient Representative: Please make sure all appropriate sections above are completed. Do not sign a blank authorization form.

_____	_____	_____
Date	Signature of Patient or Authorized Person	If Authorized Person, Relationship to Patient

Patient Label

Red River Behavioral Health System
Authorization for Exchange of Information with School

_____ _____
Patient Name **DOB**

I authorize Red River Behavioral Health System and below named school to exchange (verbal/written/faxed) confidential information for the period of hospitalization beginning on _____
Date

_____ _____
Contact Person/Name of School Phone Number

_____
Address, City, State, Zip Code

_____ _____
Patient's Grade Level: Fax Number:

Special Education/IBP: ☐ Yes ☐ No

Information to be released/exchanged:
Notification of patient's hospitalization need for school assignments, books, school materials, school progress updates, plan of transition to school, school meeting schedules.

Purpose of the disclosure:
To coordinate school referral, obtain school records, assignments, information regarding behavior, special needs, and progress in regular school and hospital school.

I understand that this authorization may be revoked in writing at any time, except where actions have already been taken in reliance on it. I release Red River Behavioral Health System and the school system from all legal liability that may arise from release/exchange of information. A photocopy of this authorization is considered as valid as the original. If not previously revoked, this authorization automatically expires one year from date signed.

Parent/Guardian Name: _____

Parent/Guardian Physical Address: _____

_____

Parent/Guardian Phone Number: _____

_____ _____ _____
Parent/Guardian Signature Date Time

Patient Label

Red River Behavioral Health System
Informed Consent for Treatment

You are applying for admission as a patient at Red River Behavioral Health System (RRBHS). By accepting you as a patient at this facility, RRBHS does not warrant or agree to effect a cure, but does agree to accord you such medical care and treatment for behavioral health and substance use disorders and provide you the opportunity for recovery. No guarantee can be made as to the results of the treatment.

The following provisions shall govern the treatment, care, and accommodations provided to all patients at the facility.

By signing this document, you are consenting to medical treatments that may include physical examination assessments; psychological testing; individual group and/or family therapy; III.7-D detoxification with possible side effects and risk factors such as anxiety, delusions, depression, fatigue, fevers, headaches, nausea, seizures, and palpitations; x-ray, and minor procedures the physician may order. Prior to receiving treatment, you will be provided with education and have the opportunity to ask questions regarding the nature of the treatment, the expected benefits, risks and alternative treatment, the cost associated with treatment and limits of service(s) due to requirements from a third-party payer. The providers furnishing services to the patient may be independent contractors and not employees or agents of the hospital. You understand that a physician is not staffed on the premises 24 hours a day, but a physician is on-call and may be reached 24 hours a day by hospital staff.

1. You will receive explanation of any treatment or procedure your provider may choose to use including the risks involved and the side-effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your therapist or provider and s/he will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
2. You may request information from your provider.
3. You have the right to refuse treatment or to stop treatment at any time and for any reason. In the case where a minor is the patient/client then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. It is our hope that if you have concerns regarding your treatment or wish to discontinue you will discuss this with your provider.
4. After your initial assessments, the treatment provider will provide you with your initial diagnosis unless collateral information is needed to formulate the diagnosis. In this case, you will be provided the diagnosis as soon after the collateral information is obtained.
5. A collaborative effort will be utilized between you, your provider, and staff in the planning and ongoing treatment provided to you.
6. It is the patient's right to refuse or withdraw consent within the timeframes covered by the consent.

Patient Label

Red River Behavioral Health System
Conditions of Admission

1. **GENERAL DUTY NURSING:** The hospital provides the patient with general nursing care. This nursing care includes promotion and prevention of illness and injury and carrying out of physician's orders within the scope of practice.
2. **MEDICAL EMERGENCIES:** It is my understanding that during hospitalization at RRBHS, medical emergencies may arise which would require transferring the patient to a general facility to best treat the condition. For this reason, I am authorizing a general care facility to treat the named patient for any condition that might occur.
3. **PERSONAL VALUABLES:** The hospital maintains a safe for the safekeeping of money and valuables. The hospital shall not be liable for the loss or damage to money, clothing, jewelry, dentures, or any other personal property, unless deposited with the hospital for safekeeping.
4. **CONTRABAND ITEMS:** The undersigned agrees and understands that drugs, alcohol, weapons, or other articles specified as contraband by the hospital may not be brought onto the premises, and that failure to abide by this rule could result in immediate discharge.
5. **PHOTOGRAPHS:** The undersigned hereby consents to the taking of a photograph for the purpose of identification. The photograph may be permanently retained in the patient's medical records. I understand the photograph will be used only for the purpose described and will not be otherwise released without my express permission.
6. **VIOLENCE-ZERO TOLERANCE POLICY:** I understand that RRBHS enforces a Zero-Tolerance policy regarding violence (verbal or physical). RRBHS and/or all parties have the right to pursue legal action against any patient who engages in violence, either verbal or physical, against staff members, patients, visitors, or others while on hospital premises. RRBHS enforces a Zero-Tolerance policy regarding the use or supplying of mood-altering drugs or illegal substance; excessive non-compliance with medical care and/or clinical treatment recommendation; fraternizing; sexual contact with another patient; excessive violent behavior. This includes explosive outbursts, hitting, slapping, kicking, verbal threats, intimidation, or property damage; stealing; leaving RRBHS campus without permission.
7. **DISCHARGE:** A voluntary patient requesting an unexpected discharge may need to wait for an evaluation by a doctor or clinician. There is a possibility that the doctor or clinician could place the patient on an emergency hold, as required by law for any patient assessed to be a danger to self or others.
8. **PROPERTY DAMAGE:** Any damage to hospital property, caused by the patient, will be billed to the patient's account for the cost of repair or replacement, and must be paid in full on or before discharge.
9. **COMMITMENT TO PREVENT, REDUCE, AND STRIVE TO ELIMINATE THE USE OF RESTRAINT AND SECLUSION:** The use of seclusion and restraint is limited to emergencies where there is an imminent risk of self-hard, or harm to others. In the adult program with your consent, your family will be involved in your treatment; this will include notification, with the patient's permission, of a restraint or seclusion episode (parents/guardians will always be notified for children and adolescents).
10. **SECLUSION AND RESTRAINT PHILOSOPHY:** Seclusion and restraint is not considered to be a standard practice and will only be used when other less restrictive alternatives have been ineffective to protect the safety of the patient or others. If seclusion and restraint is used, it will be used in accordance with the patient's plan of care, used only as a last resort, in the least restrictive manner possible, and removed or ended at the earliest possible time. During the period of seclusion and restraint, the patient will be monitored for safety and evaluated by an RN and a physician. Patients will be informed of the reason for the seclusion and restraint and have the opportunity to discuss the event with staff when they are ready.
11. **PATIENT RIGHTS AND GRIEVANCE PROCEDURE:** By signing this document, you acknowledge that you have been informed of and understand your rights as a patient and the grievance procedure.

Patient Label

Red River Behavioral Health System
Conditions of Admission

13. **PARENT/GUARDIAN WAIVER OF CLAIMS:** Parent/guardian permission must be secured for participants who are not oflegal age (18 years) and adult patients with guardians. If you are not yet classified as a legal adult, or you are an adult with a guardian, your parent/guardian must sign a separate form for parent/guardian waiver of claims.

I have read and understand the Informed Consent for Treatment & Conditions of Admission, and I have had the opportunity to ask questions and have them answered to my satisfaction. My signature below authorizes my informed consent and agreement to the Conditions of Admission for consecutive inpatient and/or outpatient treatment at RRBHS. A copy of this form is as effective and valid as the original.

Patient Label

Red River Behavioral Health System
Patient Confidentiality Contract

You understand that you have a duty to maintain the confidentiality of whatever is revealed in treatment. You also agree that you have a responsibility to respect the need for confidentiality and to maintain it. Therefore, you agree to not disclose the names of other patients and any other information that is revealed by your peers in treatment. You ask your peers to have the same obligations to respect your right to confidentiality. You understand that you may be subject to discharge while a patient if in violation of this agreement.

You may request access to your records we maintain and to know where records have been sent. Records will not be released directly to you as the patient or parent/guardian without a record review meeting with the attending physician.

Information will be furnished to persons outside the hospital upon your written authorization, except in the following circumstances where a written authorization is not necessary to release information:

I. An individual is a danger to self and/or others
2. Child abuse and neglect cases
3. Court ordered information
4. Abuse or neglect of vulnerable adults

ADDITIONAL CONFIDENTIALITY NOTICE OF ALCOHOL AND DRUG ABUSE RECORDS

Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records. Generally, program staff may not say to any outside person that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuse client UNLESS:

I. The patient consents in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency.
4. The disclosure is made to qualified personnel for research, credit, or program evaluation.

Violations of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law restricts the use of any information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal law does not protect any information about a crime committed by a patient either at the program site or against any hospital employee, or about any threat to commit a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate State and local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal law and 42 CFR part 2 for Federal regulations).

By signing this document, you acknowledge that you have been advised of the hospital policy regarding confidentiality and agree to protect the confidentiality of other patients you encounter while involved with RRBHS.

Patient Label

Red River Behavioral Health System
Patient Confidentiality Contract

I understand that I have a duty to maintain the confidentiality of whatever is revealed in treatment. I also agree that I have a responsibility to respect the need for confidentiality and to maintain it. Therefore, I agree not to reveal last names of other patients and or any other information, which is revealed by my peers in treatment. I ask my peers to have the same obligations to respect my right to confidentiality. I understand that I may be subject to discharge while a patient if I violate this agreement.

Patient Label

Red River Behavioral Health System
Patient's Bill of Rights

Subject to certain limitations authorized by a parent, legal guardian, legal custodian or a court of law concerning a minor or guardian of an incapacitated person or restrictions by the treating physician or psychiatrist, each patient has the:

1. Reasonable access to carefree of discrimination based on race, color, religion, sex or sexual preference, national origin, age, mental or physical disability, marital status, status regard to public assistance or any other category protected by state or federal law.
2. To know the identity of individuals providing services.
3. Be informed of your health status.
4. Obtain current information concerning care in terms you can reasonably be expected to understand and to participate in the planning of your care.
5. Have a representative of your choice make informed decisions regarding your care as allowed under state law.
6. Have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital.
7. To receive necessary information to give informed consent prior to the start of any procedure and/or treatment. You also have the right to withdraw or refuse consent at any time.
8. To refuse treatment, as permitted by law, and after you have been informed of potential consequences of that action.
9. At your request and expense, to seek consultation or a second opinion.
10. To transfer to another facility depending upon patient condition.
11. To formulate an Advance Directive and have staff comply with this directive.
12. To be informed of hospital policies and regulations.
13. To care that maintains personal privacy, dignity and respect.
14. To receive care in a safe setting insofar as the hospital practices are concerned.
15. To be free from abuse or harassment insofar as the hospital practices are concerned.
16. To receive care in the least restrictive environment necessary to achieve treatment goals.
17. To be free from unnecessary restraint, seclusions and medication.
18. To the confidentiality of your clinical records.
19. To access information contained in your clinical record; the hospital will seek to meet your request as quickly as its record keeping system permits.
20. To visitors, mail, telephone and other communication in keeping within the guidelines of each specific program. You have the right to restrict visitors. The hospital may need to restrict visitors or other communication at times to protect your health, safety and/or privacy.
21. To treatment consistent with acceptable professional standards of practice and the right to file a grievance if not satisfied with care received.
22. To examine your bill and have it explained when needed.
23. Medicare patients have the right to receive a beneficiary notice of non-coverage and the right to appeal premature discharge.

PATIENT RESPONSIBILITIES

1. Provide accurate and complete information regarding my health.
2. Follow the treatment plan recommended by the provider(s) responsible for my care.
3. Be responsible for my actions if treatment is refused and/or does not follow my provider's instructions.
4. Understand my insurance coverage policy and provide my insurance information to the hospital.
5. Assure that financial obligations are fulfilled promptly.
6. Be considerate of the privacy and rights of other patients, including maintaining their confidentiality.
7. Be courteous and respectful of the property of others and of the facility. I understand I am responsible for paying for damages caused by me.
8. Ensure my valuables (including, but not limited to, hearing aids, dentures, glasses, etc.) are secured at all times and are not left where they can be mistakenly disposed of (i.e., meal tray, bedside tables, etc.). RRBHS does not accept financial responsibility for lost valuables.
9. Follow facility rules and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital.

Patient Label

Red River Behavioral Health System
Advocacy Services

North Dakota: Advocacy Services

Legal Services of North Dakota, Inc., 1025 3"' St. N., Bismarck, ND 58502 (1-800-634-5263)
Grand Forks County States Attorney, 124 S. 4th St., Grand Forks, ND 58201 (701-780-8281)
Grand Forks County Social Services, 151 S. 4th St., Suite 201, Grand Forks, ND 58201 (701-787-8500)
Mental Health Association, 124 N. 8th St., Fargo, ND 58102-4915 (701-237-5871)
Protection & Advocacy Project (ND), 311 S. 4th St., Grand Forks, ND (701-795-3800)

I have been informed of my rights as a patient and I have been given the opportunity to ask questions. I have ***received notice of non-discrimination.***

Patient Label

HIPAA- NOTICE OF PRIVACY PRACTICES[1]

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

If you have any questions about this notice, please contact the Privacy Officer at 701-772-2500.

WHO WILL FOLLOW THIS NOTICE

This notice describes the privacy practices of Meridian Behavioral Health and that of our affiliated facilities, employees, and associates.

OUR PLEDGE REGARDING PATIENT CARE INFORMATION

We understand that your patient care information is personal. We are committed to protecting your patient care information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to medical records generated by each facility regarding your care.

This notice will tell you about the ways in which we may use and disclose patient care information about you. We also describe your rights to the patient care information we keep about you and describe certain obligations we have regarding the use and disclosure of your patient care information.

We are required by law to:

- Ensure that patient care information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to patient care information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PATIENT CARE INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose patient care information. For each category of uses or disclosures we will explain what we mean and try to give examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use patient care information about you to provide you with patient care treatment or services. We may disclose patient care information about you to the doctors, nurses, counselors, technicians, health students, or other personnel who are involved in taking care of you. They may work at our facilities or other healthcare providers to whom we may refer for a consultation, to take x-rays, to perform lab tests, to have prescriptions filled or other treatment purposes. We may also disclose health information about you to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status, and location.
- **For Payment.** We may use and disclose patient care information about you so that the treatment and services you receive from us may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your treatment so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose patient care information about you for operations of our facilities. These uses and disclosures are necessary to run our facilities and make sure that all of our patients receive quality care. For example, we may use patient care information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine patient care information about many patients to decide what additional services the we should offer, what services are not needed, whether

[1] **In the event that State Regulations pertaining to privacy are stricter than Federal Regulations, Meridian** Behavioral Health will follow the State Regulations.

certain new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of patient care information so that others may use it to study healthcare delivery without learning who our specific patients are.

- **For Health Care Operations.** We may use and disclose patient care information about you for operations of our facilities. These uses and disclosures are necessary to run our facilities and make sure that all of our patients receive quality care. For example, we may use patient care information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine patient care information about many patients to decide what additional services the we should offer, what services are not needed, whether certain new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of patient care information so that others may use it to study healthcare delivery without learning who our specific patients are.
- **Health-Related Services and Treatment Alternatives.** We may use and disclose patient care information to tell you about services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to send you this information or if you wish to have us use a different address to send this information to you.
- **Healthcare Oversight Activities.** We may disclose medical information to agencies with authority to conduct government oversight activities.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you 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.
- **Public Health Risks.** We may disclose patient care information about you for public health activities. These activities generally include the following:
    - To prevent or control disease, injury or disability
    - To report reactions to medications or problems with products
    - To notify persons or organizations required to receive information on FDA-regulated products
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    - To notify 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.

SPECIAL SITUATIONS

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose patient care information about you in response to a court or administrative order. We may also disclose patient care information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information to an authorized law enforcement official, as required or authorized by law.
- **Coroners, Health Examiners, and Funeral Directors.** We may release patient care information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release patient care information about patients to funeral directors as necessary to perform their duties.
- **National Security and Intelligence Activities.** We may release patient care information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose patient care information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING PATIENT CARE INFORMATION ABOUT YOU

You have the following rights regarding patient care information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy patient care information in your medical record. Usually this includes health and billing records. To inspect and copy patient care information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, including but not limited to psychotherapy notes or other documentation that is deemed to pose a threat lo the patient's health safety or welfare. If you are denied access to your information, you may request that the denial be reviewed. Another qualified individual chosen by us will review your request and the denial. The individual conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that patient care information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us.
    - To request an amendment, your request must be made in writing and submitted to your counselor and must be contained on one page of paper legibly handwritten or typed in at least 10-point font size. In addition, you must provide a reason that supports your request for an amendment.
    - We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
        - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
        - Is not part of the patient care information kept by or for our facility;
        - Is not part of the information that you would be permitted to inspect and copy; or
        - Is accurate and complete.
    - Any amendment we make to your information will be disclosed to those with whom we disclose information as previously specified.

- **Right to an Accounting of Disclosures.** You have the right to request a list accounting for any disclosures of your patient care information we have made except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this list of disclosures, you must submit your request in writing to your counselor. Your request must state a time period, which may not be longer than 6 years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if you are unable to supply the list within that time period and by what date we can supply the list, but this date will not exceed a total of 60 days from the date you made the request.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on thepatient care information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the patient care information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
  For example, you could ask that we not information to your spouse. We are not required to agree to your request restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care, we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Nurse Manager. In your request, you must tell us what information you want to limit; and to whom you want us to limit and to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health 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 to a post office box. To requestconfidential communications, you must make your request in writing to the Nurse Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Patient Label

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. To obtain a paper copy of this notice, contact your counselor or the Nurse Manager.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We retain the right to make the revised or changed notice effective for patient care information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, the effective date. In addition, each time you register for treatment, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact your counselor. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF PATIENT CARE INFORMATION

Other uses and disclosures of patient care information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose patient care information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose 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.

Acknowledgement of Receipt of this Notice. We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name/date. This acknowledgement will be filed with your records.

Patient Label

Red River Behavioral Health System
Patient Relations and Patient Rights

We recognize that all feedback from patients, families, visitors, and all others we interact with, is an important part of continuous improvement in our system. Your needs are important to us; therefore, we encourage you to share any needs or concerns you may have with the staff available to you as they arise.

You may also contact our Patient Relations Representative, LaVonne M., Director of Quality Management, at (701) 772-2500 or toll free at (866) 772-2500 during regular business hours Monday through Friday 8 am to 5 pm. After business hours, you can speak to the Nursing Supervisor on shift. We will strive to resolve any needs you may have as quickly as possible to make your stay more comfortable, so that you can focus on your treatment.

You may file a formal complaint or grievance either verbally or in writing, at any time if you feel an issue is not resolved. An investigation will be initiated, and you will be notified of the status within ten days of receipt of complaint. Any verbal response given will be followed up by a written response.

You may file a complaint and recommend changes regarding care, treatment, or services without being subject to coercion, discrimination, or reprisals, or to interruptions of care, treatment, or services that could adversely affect the individual served.

You also have the right to lodge a complaint or grievance with the State agency listed below at any time.

North Dakota Department of Health
600 East Boulevard Avenue
Bismarck, ND 58505-0200
(701) 328-2352

If you are a Medicare beneficiary or representative and you have a complaint regarding quality of care, disagree with a coverage decision, or wish to appeal a premature discharge, you have the right to contact the State Quality Improvement Organization listed below.

North Dakota Health Care Review
800-31" Avenue South West
Minot, ND 58701
(701) 852-4231

Patient Label

Red River Behavioral Health System
Patient Relations and Patient Rights

Patient Rights

Upon admission, your rights as a patient are presented to you and your personal representative, if applicable, in a manner and form that can be understood by you as the patient. The patient rights are listed below:

All patients will be treated with dignity and respect. RRBHS takes all appropriate actions to maintain an environment free from discrimination, harassment and from offensive or degrading remarks or conduct, including harassment or discrimination based on race, color, religion, sex or sexual preference, national origin, age, mental or physical disability, marital status, status with regard to public assistance or any other category protected by state or federal law.

I. A patient has the right to receive a beneficiary notice of non-coverage and the right to appeal premature discharge.

2. A patient has the right to participate in the development and implementation of his or her plan of care.

3. A patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.

4. A patient has the right to be informed of his or her health status, be involved in care planning and treatment, and be able to request or refuse treatment.

5. A patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of the patient's admission to the hospital.

6. A patient has the right to personal privacy.

7. A patient has the right to receive care in a safe setting.

8. A patient has the right to be free from all forms of abuse or harassment.

9. A patient has the right to the confidentiality of his or her clinical records.

10. A patient has the right to access information contained in his or her clinical records with the supervision of the treating physician within a reasonable time frame.

11. A patient has the right to file a written grievance with the hospital, and to be informed of the grievance process.

12. A patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.

13. A patient has the right to be free from unnecessary seclusion and restraints.

*For further information on patient rights, please see any staff member.

Patient Relations Program

Patient Label

Red River Behavioral Health System
Financial Agreement

At Red River Behavioral Health System, we are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an important element of you care and treatment. The Financial Policy is to assist you. If you have questions, please feel free to discuss them with our Patient Accounts Staff.

Unless either you of your health coverage carrler have made other arrangements in advance, full payment is due at the time of service. For insured patients, this included any co-payments, co-insurance amounts and/or deductibles.

YOUR INSURANCE: If you have insurance, we will file your claim with your insurance company, as a courtesy to you. We will extend payment terms up to 60 days in order to provide you with enough time to resolve your insurance claims. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. For people covered by more than one policy, we also file claims to the "secondary" insurance.

As insurance carries tend to change frequently, it Is the policyholder's responsibility to determine whether or not we are contracted providers before being seen. To allow for filing of your insurance benefits, you must bring your insurance acer upon admission as well as at any time your insurance coverage changes. Please be aware that few insurance companies attempt to cover all medical costs. You are responsible for payment regardless of any insurance company's determination of usual and customary rates that may bear relationship to the current standard and cost of care in this area. If there are any disputes with your insurance carrier regarding you policy guidelines and insurance payments, it is important that you be involved to insure that you receive the full benefit due to you. Insurance policies vary widely in how they pay for mental health services. Often pre-authorizations are required for a specific number of visits. In some cases, an initial referral from a primary care doctor is needed. Depending on your policy, your involvement may be critical, for some stapes in the process, such as obtaining an initial referral.

I Authorize Red River Behavioral Health System to contact my primary care physician/ Managed Care Network on my behalf to request a referral that may result in coverage at the "in Network" benefit level.

Authorization for release of information to Insurance Companies: By initialing and sighing below, you are authorizing Red River Behavioral Health System to release medical information to your insurance company, including governmental payers such as Medicare, Medical Assistance and Worker's Compensation as required or permitted by law. This includes but may not be limed to confidential medical information which may include drug/alcohol abuse, HIV status, or psychiatric treatment as necessary for payment of claims. This may include verbal, written or faxed information.

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand.

Your doctor or therapist can explain the reasons for the different kind of charges used, such as evaluations, individual therapy, or family therapy.

METHODS OF PAYMENT; We accept cash, check, VISA, and MasterCard. We do not accept post-dated checks, nor will we hold checks for a length of time. Payment arrangements may be made in advance of your appointment as necessary.

INFORMATION CHANGES: Be sure to advise us of any address or phone number changes. We cannot be responsible for delinquent accounts due to lack of receipt of statements or other correspondence if we do not have a current or correct address or phone number on file.

COLLECTION PROCEDURES: Patient Account Representatives are available to help with payment arrangements from 8:00am-5:00pm Monday thru Friday, we do have a financial assistance program available for those patients who qualify. Once made in writing, agreements are binding. Our collection procedure does not begin until 30days after your insurance has paid their portions, 60 days If they have not. Failure to respond to communications from our office may result in termination of treatment and/or involvement of an outside collection agency. You will be responsible for any fees or interest charged in association with collection of your account.

ASSIGNEMENT OF BENEFITS: If you have health care insurance or are entitled to benefits under any private or government health plan or policy you agree that RRBHS may bill these priors and they may make their payments directly to RRBHS. Your signature on this from is your authorized signature for the filing of a claim and request for direct payment of benefits by any payer to RRBHS.

I have read and understand this financial policy of RRBHS and\ agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient Label

Red River Behavioral Health System
Parent/Guardian Waiver of Claims

Parent/guardian permission must be secured for participants who are not of legal age (18 years). If you are not yet classified as a legal adult, your parent or legal guardian must complete the following:

I give permission for my child to participate in Red River Behavioral Health System program. Should my child become injured or ill, I request that Red River Behavioral Health System staff secure emergency medical services to aid my child, if in their judgment such services are necessary. I agree to incur any additional expenses associated with such action. As a parent/guardian, I have decided (with or without medical advice) that my child is physically, . mentally, and socially able to participate, and I acknowledge that any medical or accident insurance I consider necessary will be my responsibility to locate and purchase.

Patient Label

Red River Behavioral Health System
Unit Guidelines

1. Luggage: 3 changes of clothing are allowed. Clothing may not have strings or hoods. Excess clothing will be sent home with family/friends, along with the suitcases, backpacks, etc. Coats, boots, etc. are stored in a closet.
2. Clothing: Unit policy requires that all clothing be checked before being put in the patient's room, which includes the clothing that the patient is wearing. There are laundry facilities. Each population has designated times for their laundry. Staff will assist patients with laundry.
3. Patient belongings: No belongings other than personal care items, schoolbooks, or leisure magazines may be brought in. Food or drinks are not to be brought in due to infection control issues.
4. Security checks: All patients and their belongings will be checked with a security wand to ensure safety of self and others. In additions, clothing, pockets and belongings will be patted down/checked as additional measure in securing safety of patients and environment.
5. Personal Care Items: Personal care items are stored in a "bucket". The patient will receive their bucket during AM and **PM** care times, and the buckets are returned to the staff and secured in a closet upon completion of cares.
6. Daily Cares: Morning cares need to be completed before the start of groups. Any cares that are not complete by that time will need to be done in the evening or the next morning. All rooms need to be cleaned (linens thrown into the soiled linen bin, bed made, etc.) before the start of groups. Breakfast is continental. Breakfast needs to be started and completed before the start of groups.
7. Meals: Meals are contracted from an outside facility, and the meals are ordered 24 hours prior to the meal served. Inpatients receive hot meals and partial patients have the option to receive a hot lunch. Every effort is made to order an adequate amount of food. In the event of a shortage of food sent over, there is an emergency supply of food available in the building.
8. Infection Control: Because of infection control issues, patients are not allowed to go into the refrigerator or cupboards and must ask staff for assistance. Also, no food or drinks are allowed outside of the dayrooms.
9. Groups start at 8:30 am. Please refer to the form Basic Rules of Group Therapy.
10. Confidentiality: For the patient's protection, any visitor or person calling will be asked to identify themselves. Staff will reference the consent form that each patient fills out to check if the patient has allowed that person to have access to knowledge of the patient's whereabouts. Please refer to the form Patient Confidentiality Contract. Callers are limited to immediate family members.

Patient Label

11. Smoking policy: Red River Behavioral Health System is a smoke free environment. No smoking is permitted on the hospital grounds.
12. Telephone usage: The telephone usage times are posted on the window at the workstation.
13. Visiting hours: Visiting hours are posted at the window in the workstation. NO visitors are allowed in the patient's room. During winter months, visitors may be asked to leave their coats in the hospital lobby. Any items brought in by visitors need to be brought to the workstation and checked by the staff. No food or drink, radio, etc. may be brought in and will be sent home with family/friends.
14. Safety: Safety issues are one of the main concerns on the unit. Many of the guidelines relate to safety issues, so please ask staff if you have any concerns. Safety checks may be performed per staff discretion.
15. Partial patients should be checked daily for sharps, drugs, etc.
16. If partial patients are intoxicated when they come in, they will be sent home and will need to arrange a ride, taxi, etc. If they insist on driving, they need to be informed that the police will be notified, and their license plate will be given to the officer.

Patient Label

Red River Behavioral Health System
Patient Orientation Guide

Following orientation to the unit, the Patient Orientation Checklist (separate document) shall be signed and dated by the ***patient/guardian and filed in the patient 's medical record. This document is to be given to the patient for reference.***

Daily Cares/Patient Cubbies
Patients will be provided with their toiletries cubby at the start and end of each day to complete their daily care needs. After completion of daily cares, the toiletries cubby will be returned to the nursing staff that will place it in the designated, locked storage area. Any supervised items will be placed in a separate, labeled bag and stored in a locked storage area.

Breakfast Meal
Breakfast will be served ala carte by nursing staff on or about the following times daily:

Adolescents	8:00 a.m.
Adults	8:00 a.m.
Children	8:00 a.m.
Geriatrics	8:00 a.m.

Other Meals
At the start of each day, you will make your selection for the noon and evening meals for the next day. Lunch and Supper Meals times occur on or about the following times daily:

Adolescents	Lunch: 12:00 noon	Supper: 6:30 p.m.
Adults	Lunch: 12:00 noon	Supper: 6:30 p.m.
Children	Lunch: 12:00 noon	Supper: 6:30 p.m.
Geriatrics	Lunch: 12:00 noon	Supper: 6:30 p.m.

Snacks
Snacks will be provided at scheduled times and served ala carte by nursing staff.

Infection Control in Dayrooms
Staff will obtain all food/drink for you from the refrigerator or cupboards in the dayrooms. Patients are not allowed to retrieve items from these areas as it is an infection control issue and food handlers must be gloved. All food/drink items must be consumed in the dayroom. Food or beverage items may not be brought into the facility by patients or family members.

Group Times
The daily group schedule is posted at the main workstation for easy reference. Notify staff at centralized workstation if group has not started within 10 minutes of scheduled time.

Telephone Times
Daily telephone times are available for family contact. Contact to child and adolescent patients must be initiated by authorized family members. Please limit your calls to 5 minutes as other patients are also expecting calls from family members. Special telephone times may be reviewed on case-by-case basis to meet family needs. Telephone times occur on or about the following times daily:

Adults	Mon-Fri: may make out going business related calls between 8:30-9:30am
	Sun-Sat: (7 days a week): 5:00pm – 6:30pm
Adolescents/Children	Mon-Fri: 5:00pm – 6:30pm
	Sat/Sun: 1:00pm – 3:00pm

Patient Label

Red River Behavioral Health System
Patient Orientation Guide

Visiting Hours/Rules
Visiting hours are generally for family members only. Exceptions are made on a case-by-case basis. We recommend that family members under the age of 12 not visit unless approved in advance by the treatment team. Due to the large number of visitors in a confined area, a patient should not have more than three visitors at a time. No food/drink is to be brought in for visiting times due to infection control issues. No gifts are to be brought in. Flowers are acceptable in plastic containers. Visiting hours occur on or about the following times daily:

Adults	Sun-Sat (7 days a week	5:00pm – 6:30pm
Adolescents	Mon- Fri (5 days a week)	5:00pm – 6:30pm
	Sat/Sun	1:00pm – 3:00pm

Radio Usage
Radios or other electronic devices to play music are not permitted on the hospital units for safety reasons.

Television Usage
The times for television use are designated in programming schedule.

Precautions
Patients are assessed for appropriateness of being placed on precautions for high-risk behavior:

- Self-harm: The patient is at risk of harming self.
- Suicide: The patient is at risk of harming self with a fatal outcome.
- Aggression: The patient is at risk of inflicting harm upon others.
- Elopement: The patient is at risk of unauthorized exit from the building.
- Falls: The individual is at risk for falls.

Safety Checks

- Our goal is to be a sharp-free environment, and we make every effort to achieve this to maintain a safe, therapeutic environment.
- Fifteen-minute safety checks will be conducted by staff 24 hours a day on every patient. If you have needs during these times, please let staff know.
- Patient rooms will also be checked daily for any items deemed unsafe. Items will be placed in the designated luggage area.
- Upon admission and returning from passes, all patients will be asked if they have any contraband items and will be searched for any unsafe items. All patient belongings will be checked for unsafe items.
- Items requiring staff supervision will be kept in your individual cubby in the designated locked storage area when **not in use.**
- Fire drills are performed on a regular basis for your safety. Follow directions provided by staff.

Laundry Facilities
Laundry is done during non-group times. Staff will assist with laundry when needed. Laundry is to be placed in a bag marked with your name and room#.

Personal Items
All personal items will be stored in your dresser or armoire. Any unauthorized items will be sent home or placed in the designated luggage area. You may wear soft-soled slippers or soft soled shoes on the units.

Smoking Policy
Red River Behavioral Health System is a smoke free environment. No smoking is permitted on the hospital grounds.

Patient Label

Red River Behavioral Health System
Patient Orientation Checklist

Directions: Staff to orient patient to each item, date/initial each item, and obtain patient signature upon completion of orientation. This checklist is to be maintained in the patient's medical record.

Item	Date	Employees initials
Daily Cares/Storage of Personal Care Items		
Personal Belongings		
Mealtimes		
Group Times and Rules		
Telephone Times		
Visiting Hours and Rules		
Radio Usage		
Laundry Facilities		
Hospital Communication Systems (i.e. overhead paging")		
Tobacco Free Environment		
Infection Control		
Precautions		
• Self-harm		
• Suicide		
• Aggression		
• Elopement		
• Falls		
Safety Checks/Room Searches		

Patient Orientation Acknowledgment

I have been oriented to all items as evidenced by my signature below.

_____
Patient Name

_____ _____ _____
Patient Signature Date Time

_____ _____ _____
Witness Signature Date Time

Patient Orientation Checklist

Patient Label

Red River Behavioral Health System
Reference list for initiating & completing
Nursing Care Plans

Patient diagnosis/ comorbidities and deficits we need to identify when initiating patient specific care plans. If any of the above affects the patient or is a risk the patient during their hospital stay, we need a care plan to address in their medical record.

At the time of admission review the following areas:

- Review all records obtained during admission process/ records sent from PCP
- Review medical hx with patient
- Review H & P & psycheval
- Diagnosis id on admission and all medication orders
- Admission patient precautions
- Nursing assessment- glasses, dentures, hearing, mobility, bowel & bladder elimination, fall risk/hx
- Patient assessment regarding patient specific deficits: ADL's, mobility, intake of food & fluids

Once patient diagnoses have been identified, then you determine which are active medical issues while in- patient. All other diagnose would be considered comorbidities. (A comorbidities divider has been added to the treatment section of each chart. The active medical nursing care plans should be placed on top of the comorbidities divider.)

All active nursing **care plan goals must be stated in "patients own words"** contained in quotation marks, their stated goal and plan to achieve.

The goal section of the nursing care plan should start with the patients stated goal with plan to achieve and transition to professional nursing goals.

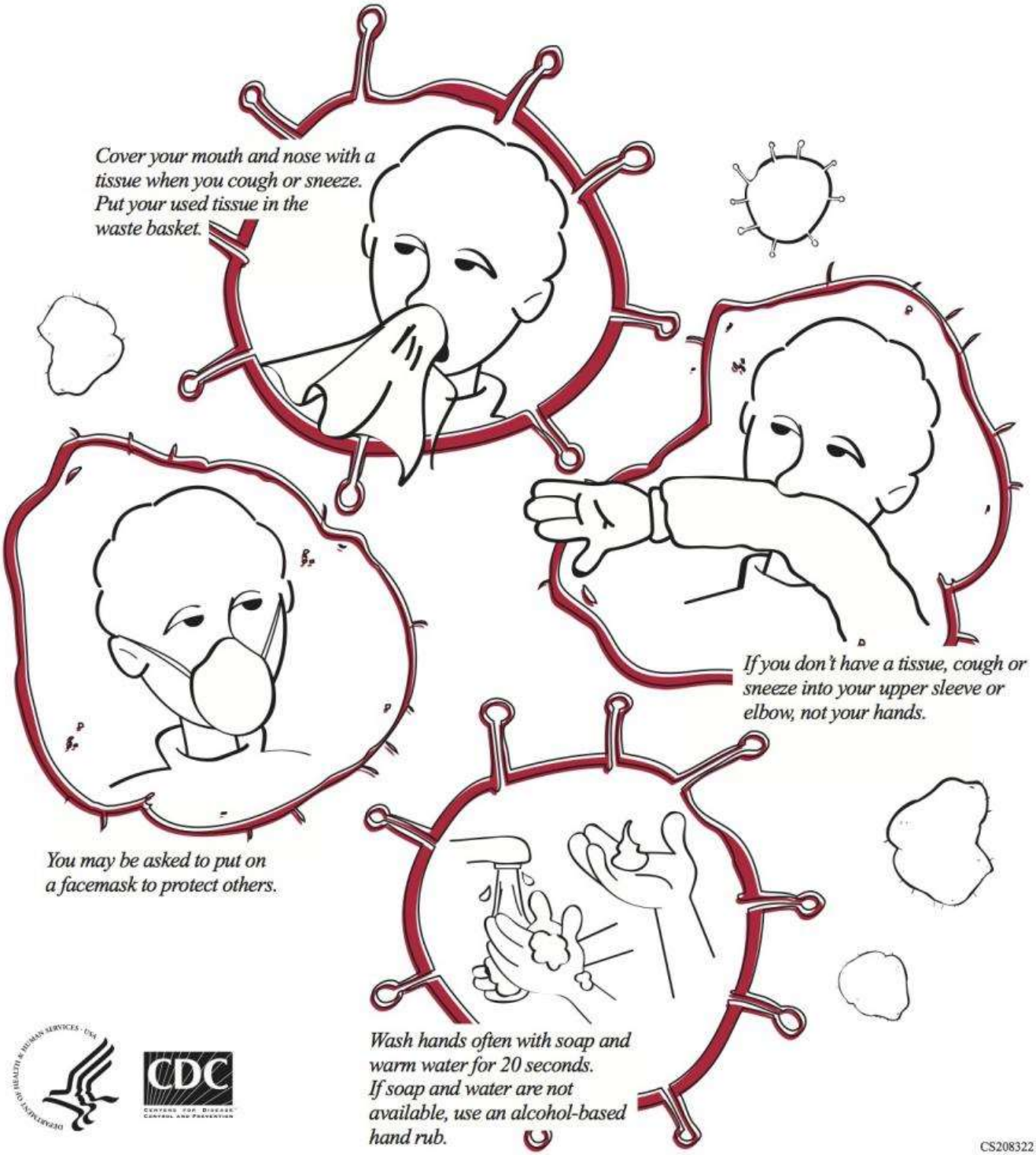
A **weekly progress note will be written** to review patients progress in treatment as well as progression in achieving their goals. (Be sure to include any newly identified effective interventions, CPI holds, changes in programing) The progress note will be written on the master treatment plan update form on a weekly basis, per nightshift prior to completion of the treatment plan.

Night nurses review care plans as part of the nightly chart review:

- Review new orders, medical progress notes, psych notes and H & P for new dx
- Review for onset of infection with tx of antibiotics
- Review for recent falls and the initiation of post fall care plan
- Assess for changes in patients' condition/ level of function
- Review current nursing care plans to ensure it is still an active issue, if not resolve the care plan
- Review comorbidities identify if any issues need to be moved to active.
- Review active issues, identify if any issues need to be moved to comorbidities.

Cover your Cough

Stop the spread of germs that can make you and others sick!



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Patient Label