



Tip Sheet – Sign & Submit Forms- IOS

- Mobile devices can be used to sign and submit forms – To do so you must download the Adobe Acrobat Reader app 
- The app can be downloaded for free from the App Store 

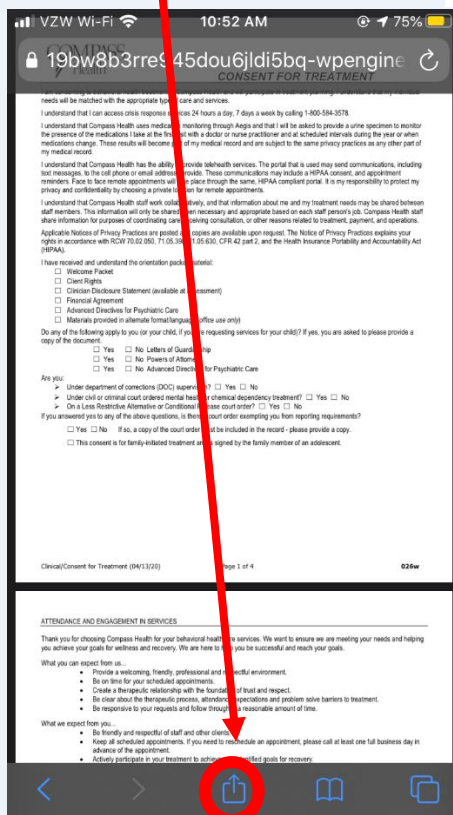
Step 1 – Select the Form –

Click the name of the Form you would like to complete and sign on the website.

- Consent for Telehealth
- Consent for Treatment
- Financial Agreement
- Release of Information (ROI)

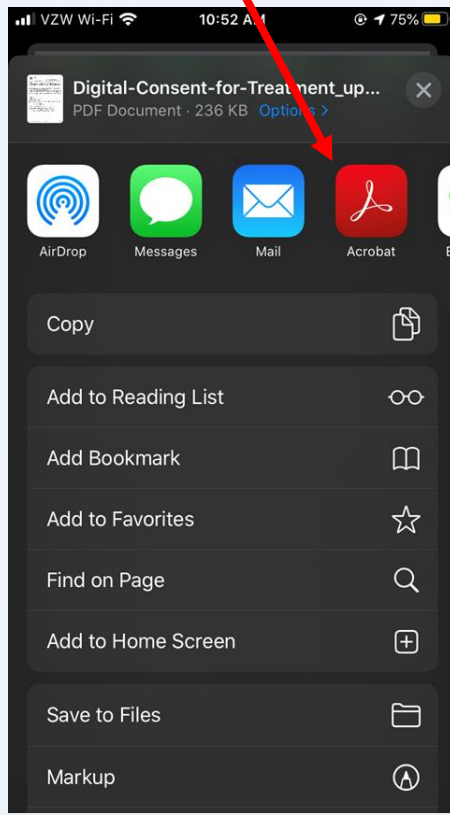
Step 2 – Download the Form

Select the icon in the middle at the bottom of the screen.

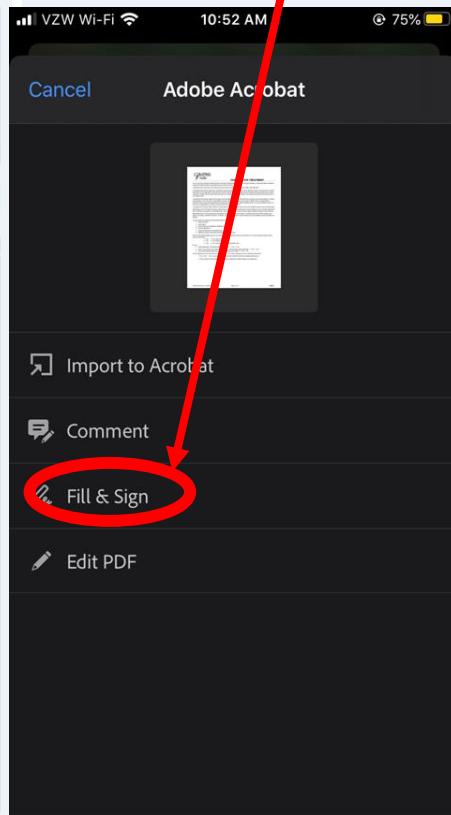


Step 3 – Open the Form

Open the form in the Adobe Acrobat App

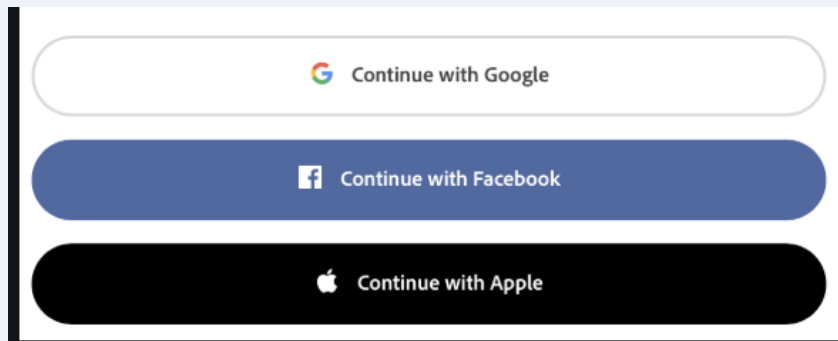


Step 4 – Select Fill & Sign



Tip Sheet – Sign & Submit Forms- IOS

You may encounter a pop-up screen: It will ask you to sign in using either Google, Facebook, or Apple. Instead click the X icon in the upper right-hand corner to bypass this popup



Step 5 - Fill in the Form - Fill in the form by clicking the check boxes and the blue text boxes.

This Authorization is effective (date):

Step 6 – Apply your signature –

After you have completed the form and you are ready to sign it select the icon in the middle of the bottom of the screen. Then select “Create Signature”

COMPASS Health
CONSENT FOR TREATMENT

I am consenting to behavioral health treatment at Compass Health and will participate in treatment planning. I understand that my individual needs will be matched with the appropriate type of care and services.

I understand that I can access crisis response services 24 hours a day, 7 days a week by calling 1-800-564-3578.

I understand that Compass Health uses medication monitoring through Apps and that I will be asked to provide a urine specimen to monitor the presence of the medications I take at the first visit with a doctor or nurse practitioner and at scheduled intervals during the year or when medication changes. These results will become part of my medical record and are subject to the same privacy practices as any other part of my medical record.

I understand that Compass Health has the ability to provide telehealth services. The portal that is used may send communications, including messages, to the cell phone or email address I provide. These communications may include a HIPAA consent, and appointment reminders. Face to face remote appointments will take place through the same, HIPAA compliant portal. It is my responsibility to protect my privacy and confidentiality by choosing a private location for remote appointments.

I understand that Compass Health staff work collaboratively, and that information about me and my treatment needs may be shared between staff members. This information will only be shared when necessary and appropriate based on each staff person's job. Compass Health staff share information for purposes of coordinating care, receiving consultation, or other reasons related to treatment, payment, and operations.

Appendix: Notices of Privacy Practices are posted and copies are available upon request. The Notice of Privacy Practices explains your rights in accordance with RCW 70.02.050, 71.05.360, 71.05.630, CFR 42 part 2, and the Health Insurance Portability and Accountability Act (HIPAA).

I have read, understand and agree to the orientation packet material:

- ☐ Privacy Fact Sheet
- ☐ Rights
- ☐ Clinical Disclosure Statement (available at assessment)
- ☐ Financial Statement
- ☐ Advance Directives for Psychiatric Care
- ☐ Material provided in alternate format/language (office use only)

Do any of the following apply to you (or your child, if you are requesting services for your child)? If yes, you are asked to please provide a copy of the document.

- ☐ No Letters of Guardianship
- ☐ No Powers of Attorney
- ☐ No Advance Directives for Psychiatric Care

Are you:

- ☐ Under departmental corrections (DOC) supervision? ☐ Yes ☐ No
- ☐ Under civil or criminal court ordered mental health or chemical dependency treatment? ☐ Yes ☐ No
- ☐ On a Less Restrictive Alternative or Conditional Release court order? ☐ Yes ☐ No

If you answered yes to any of the above questions, is there a court order exempting you from reporting requirements?
☐ Yes ☐ No If yes, a copy of the court order must be included in the record; please provide copy.

☐ This consent is for non-related treatment and is signed by the family member of an adolescent.

Clinical/Consent for Treatment (04/13/20) Page 1 of 4 026w

ATTENDANCE AND ENGAGEMENT IN SERVICES

Thank you for choosing Compass Health for your behavioral health services. We want to ensure we are meeting your needs and helping you achieve your goals for wellness and recovery. We are here to help you be successful and reach your goals.

What you can expect from us...

FINANCIAL AGREEMENT

I agree to the assignment of all insurance payments to Compass Health, P.O. Box 3810, Everett WA 98213. I authorize my insurance carrier to pay benefits directly to the agency. I agree to forward any insurance payments I might receive directly to the agency. Insurance does not guarantee benefits. I am responsible for fees not covered by insurance.

I understand that I am responsible for any amounts applied to my insurance deductible and any amount not paid by my insurance.

I agree to inform COMPASS HEALTH of any changes in the financial information given.

I agree to pay promptly all fees for which I am responsible. Financial assistance may be available for low-income or other qualifying clients.

RELEASE OF INFORMATION / AUTHORIZATION OF INSURANCE BENEFITS

I authorize COMPASS HEALTH to disclose all or any part of my medical records, including mental health and alcohol and drug abuse records, to representatives of my insurance companies in order to process its claim.

For Substance Use Disorder Treatment:

I authorize release to my insurance provider, or payer for my SUD services, listed here:

- ☐ American Psychiatric Association
- ☐ Community Health Plan of Washington
- ☐ Coordinating Care
- ☐ Molina Healthcare
- ☐ United Health Group
- ☐ North Sound Behavioral Health Administrative Service Organization
- ☐ Other: _____

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service.

I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it. Acting in reliance on this authorization, the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding alcohol and substance abuse treatment information to law enforcement for the collection of vital statistics or an investigation into the cause of death.

I have read, been offered a copy of and agree to the above conditions. Unpaid fees are subject to collection.

Client Signature _____ Date _____

Parent / Guardian Signature _____ Printed Name _____ Date _____

Create Signature

Create Initials

Cancel

Tip Sheet – Sign & Submit Forms- IOS

Draw your signature on the screen. Tap 'Clear' on the bottom right-hand corner to erase any mistakes. When satisfied with the result select 'Done' in the upper right-hand corner.



Tap the form to place the signature on the signature line. You can change the size of your signature by moving the blue icon.

Digital-Consent-for-...updated-2020.04.20 PDF

FINANCIAL AGREEMENT

I agree to the assignment of all insurance payments to Compass Health, P.O. Box 3810, Everett WA 98213. I authorize my insurance carrier to pay benefits directly to the agency. I agree to forward any insurance payments I might receive directly to the agency. Insurance does not guarantee benefits. I am responsible for fees not covered by insurance.

I understand that I am responsible for any amounts applied to my insurance deductible and any amount not paid by my insurance.

I agree to inform COMPASS HEALTH of any changes in the financial information given.

I agree to pay promptly all fees for which I am responsible. Financial assistance may be available for low-income or other qualifying clients.

RELEASE OF INFORMATION / AUTHORIZATION OF INSURANCE BENEFITS

I authorize COMPASS HEALTH to disclose all or any part of my medical records, including mental health and alcohol and drug abuse records, to representatives of my insurance companies in order to process this claim.

For Substance Use Disorder Treatment:

I authorize release to my insurance provider, or payer for my SUD services, listed here.

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina Healthcare
- United Healthcare
- North Sound Behavioral Health Administrative Service Organization
- Other: _____

Tap anywhere to place signature

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service.

I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

I have read, been offered a copy of and agree to the above conditions. Unpaid fees are subject to collection.

Client Signature _____ Date _____

Parent / Guardian Signature _____ Printed Name _____ Date _____

Clinician Signature / Degree / Specialty _____ Date _____

Clinical/Consent for Treatment (04/13/20) Page 2 of 4 026w

Digital-Consent-for-...updated-2020.04.20 PDF

FINANCIAL AGREEMENT

I agree to the assignment of all insurance payments to Compass Health, P.O. Box 3810, Everett WA 98213. I authorize my insurance carrier to pay benefits directly to the agency. I agree to forward any insurance payments I might receive directly to the agency. Insurance does not guarantee benefits. I am responsible for fees not covered by insurance.

I understand that I am responsible for any amounts applied to my insurance deductible and any amount not paid by my insurance.

I agree to inform COMPASS HEALTH of any changes in the financial information given.

I agree to pay promptly all fees for which I am responsible. Financial assistance may be available for low-income or other qualifying clients.

RELEASE OF INFORMATION / AUTHORIZATION OF INSURANCE BENEFITS

I authorize COMPASS HEALTH to disclose all or any part of my medical records, including mental health and alcohol and drug abuse records, to representatives of my insurance companies in order to process this claim.

For Substance Use Disorder Treatment:

I authorize release to my insurance provider, or payer for my SUD services, listed here.

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina Healthcare
- United Healthcare
- North Sound Behavioral Health Administrative Service Organization
- Other: _____

Tap anywhere to place signature

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service.

I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

I have read, been offered a copy of and agree to the above conditions. Unpaid fees are subject to collection.

Client Signature Peter Pan Date _____

Parent / Guardian Signature _____ Printed Name _____ Date _____

Clinician Signature / Degree / Specialty _____ Date _____

Clinical/Consent for Treatment (04/13/20) Page 2 of 4 026w

Forms with a signature or initials will not be editable once saved.

Note: When you save a form with a signature or initials, you will no longer be able to edit the form.

Tip Sheet – Sign & Submit Forms- IOS

Step 7 – Add the Date - To add the date to your signature, click on the sign icon and select create initials.

COMPASS Health
CONSENT FOR TREATMENT

I am consenting to behavioral health treatment at Compass Health and will participate in treatment planning. I understand that my individual needs will be met with the appropriate type of care and services.

I understand that I can access crisis response services 24 hours a day, 7 days a week by calling 1-800-684-3578.

I understand that Compass Health uses medication monitoring through flags and that I will be asked to provide a urine specimen to monitor the presence of the medication I take at the first visit with a doctor or nurse practitioner and at scheduled intervals during the year or when medication change. These results will become part of my medical record and are subject to the same privacy practices as any other part of my medical record.

I understand that Compass Health has the ability to provide telehealth services. The portal that is used may send communications, including text messages, to the cell phone or email address I provide. These communications may include HIPAA consent and appointment reminders. I agree to have these communications sent to me through the same HIPAA compliant portal. It is my responsibility to protect my privacy and confidentiality by providing a private location for remote appointments.

I understand that Compass Health staff work collaboratively, and that information about me and my treatment needs may be shared between staff members. This information will only be shared after necessary and appropriate based on each staff person's job. Compass Health staff share information for purposes of coordinating care, reviewing consultation, or other reasons related to treatment, payment, and operations. Applicable Policies of Privacy Practices are posted and copies are available upon request. The Notice of Privacy Practices explains your rights in accordance with 42 CFR 102.20, 102.38, 102.60, 102.61, 102.62, 102.63, 102.64, and the Health Insurance Portability and Accountability Act (HIPAA).

I have reviewed and understand the information posted material:

- ☐ Release Packet
- ☐ Client Rights
- ☐ Clinical Disclosure Statement (available at assessment)
- ☐ Financial Agreement
- ☐ Advanced Directives for Psychiatric Care
- ☐ Material provided to external for long-term use (off-site use only)

Do any of the following apply to you (or your child, if you are requesting services for your child)? If yes, you are asked to please provide a copy of the document.

- ☐ Yes ☐ No Letters of Guardianship
- ☐ Yes ☐ No Powers of Attorney
- ☐ Yes ☐ No Advanced Directives for Psychiatric Care

Are you:

- ☐ Under department of corrections (DOC) supervision? ☐ Yes ☐ No
- ☐ Under civil or criminal court ordered mental health or chemical dependency treatment? ☐ Yes ☐ No
- ☐ On a law restrictive order or Conditional Release order? ☐ Yes ☐ No

If you answered yes to any of the above questions, is there a court order exempting you from reporting requirements?

- ☐ Yes ☐ No If a copy of the court order is made available in the portal, please provide a copy.

This consent is for family-involvement treatment and is signed by the family member of an adolescent.

Clinical Consent for Treatment (04/13/20) Page 1 of 4 828w

ATTENDANCE AND ENGAGEMENT IN SERVICES

Thank you for choosing Compass Health for your behavioral healthcare services. We want to ensure we are meeting your needs and helping you achieve your goals for wellness and recovery. We are here to help you.

What you can expect from us:

Molina Healthcare
United Healthcare
North Sound Behavioral Health Administrative Service
Other:
Other:

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service.

I may revoke this consent at any time by signing and dating a formal request upon it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information.

Information approved for disclosure based on this authorization recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any substance use disorder client when required by federal or state laws for the collection of vital statistics.

I have read, been offered a copy of and agree to the above

Peter P.

Create Initials

Cancel

Draw the date and select done. Place the date in the same way that you placed the signature by tapping on the date line.

Cancel Draw Image Camera Done

4-21-20

Clear

Save to Device

Change the size of the date by moving the blue icon on the right side of the date.

Molina Healthcare
United Healthcare
North Sound Behavioral Health Administrative Service
Other:
Other:

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service.

I may revoke this consent at any time by signing and dating a formal request upon it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information.

Information approved for disclosure based on this authorization recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any substance use disorder client when required by federal or state laws for the collection of vital statistics.

I have read, been offered a copy of and agree to the above

Peter P.

Client Signature

Parent / Guardian Signature Printed Name

Clinician Signature / Degree / Specialty

Click 'Done' to save the form.

VZW Wi-Fi 10:58 AM 73%

Done

Organization

24 months from the date of my last service.

a formal request, except to the extent that action has already been taken to provide treatment services in reliance on a valid consent to disclose information.

Information approved for disclosure based on this authorization recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any substance use disorder client when required by federal or state laws for the collection of vital statistics.

ve conditions. Unpaid fees are subject to collection.

4-21-20

Date

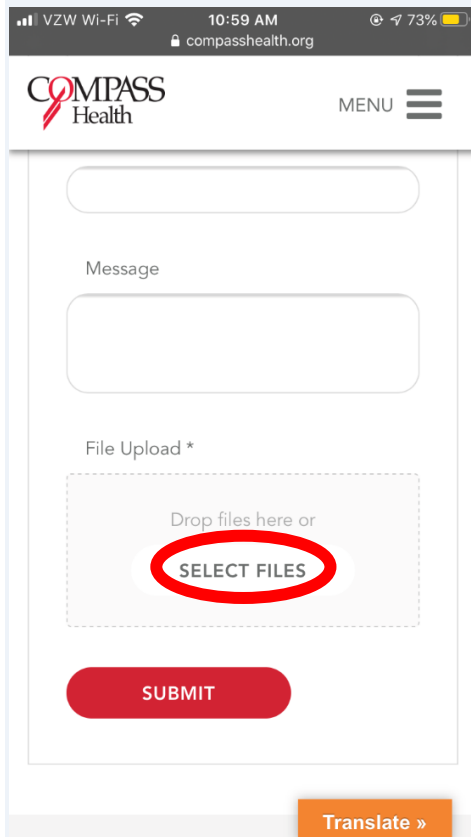
Date

Date

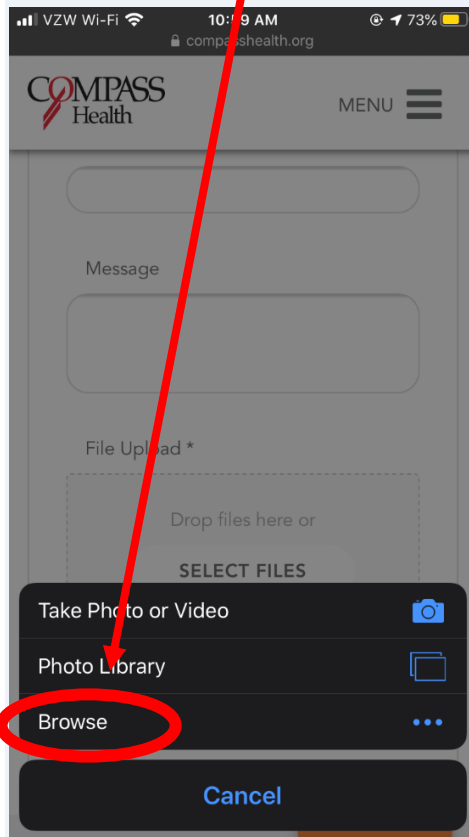
Tip Sheet – Sign & Submit Forms- IOS

Step 8 – Submitting the Forms

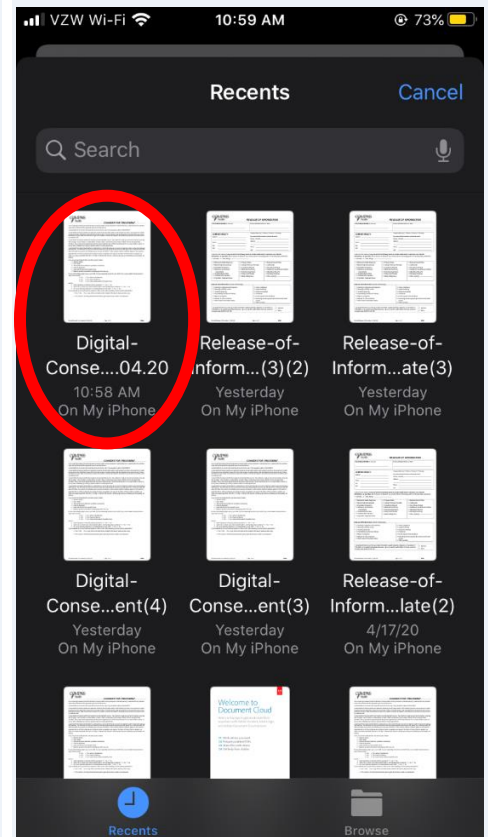
Go back to the Compass Health Client Forms website click 'Select Files'



Select the Browse option.



Click the first option on the top left corner of the recent documents.



After the Form attaches click the submit button to finish.

