PINNACLE
TREATMENT CENTERS

Pinnacle Treatment Service of Aliquippa
400 Woodlawn Road
Aliquippa, PA 15001
724.857.9640

Welcome,

Thank you for allowing Pinnacle Treatment Services of Aliquippa to assist you in your medication needs while attending Gateway Rehabilitation Center. We are proud of you for the steps you are taking to strengthen your recovery. While attending Gateway, please be advised on the information we will need prior to your stay.

- Release of information (2 way) from the home clinic
- Release of information (2 way) Pinnacle and Gateway (Please use forms attached)
- Completed guest dosing form (please use attached form)
- Letter guaranteeing return once discharged from Gateway (Please use attached form)
- Valid Photo ID present at time of medication
- Copy of all insurance cards front and back.
- Once all forms, ID, ROI's, and insurance cards are collected; please fax to Pinnacle Treatment Services directly at 724-857-9653 or PTSAguestdosing@pinnacletreatment.com (this is a secure email)
- Please send entire welcome packet to Gateway rehab to the email of CASAliquippa@gatwayrehab.org

Thank you again for choosing Pinnacle Treatment Services of Aliquippa. If you have any further questions or concerns, please contact us at your earliest convenience.

Jennifer Vaughan, MS
Executive Director

PROHIBITION ON RE-DISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressed permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release 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.

Home clinic name:
Address:
Phone Number:
Fax Number:

Date:

Client Full Name:
Date of Birth:

To Pinnacle Treatment Services:

This letter is to verify that the above referenced individual has been a client under our maintenance program since their admission date on _____. It is our understanding that this individual is being referred to Gateway Rehabilitation Center Main Campus for inpatient treatment.

The above-named client is eligible to return to our program upon discharge from Gateway and will not be discharged while inpatient.

The above named client is currently prescribed Methadone Medication with a daily dose of _____.

Please contact us if you need any further information.

Sincerely,

Home Clinic Physician/Supervisor Name:_____
Home clinic Physician/Supervisor Title: _____
Home clinic physician/Supervisor Signature: _____

Home Clinic Name:
Home clinic Address:
Home Clinic Phone/Fax:

Guest Medication

Form Prepared By: Date Prepared:

Personal Data

Patient Name: _____

Birth Date: _____ Social Security #: _____ Ethnicity: _____

Height: _____ Weight: _____ Hair: _____ Eyes: _____

Visible Distinguishing Characteristics such as tattoos, etc.: _____

_____

Photo ID attached Yes/No **(Patient will NOT be dosed without Valid photo ID)**

Sending Clinic Treatment Information:

Home Clinic: _____

Address: _____

Telephone: ( )_____ Facsimile Number: ( ) _____

Contact Staff Person(s): (for dose verification) _____

Dose: _____ mgs.

Last Day in Home Clinic: _____

First Day in Temp Clinic: _____ Last Day in Temp Clinic: _____

Travel Dose Required:_____ mgs. Date Back in Home Clinic: _____

Other Information:

_____

Travel Data: Guest dose while inpatient rehab

Temporary Phone Number: Gateway Rehab Main Campus

_____

Temporary Residence: 100 Moffet Run Road Aliquippa PA, 15001

Reason for Travel: Inpatient Rehabilitation

_____

Temporary Clinic Name: Pinnacle Treatment Services of Aliquippa

_____

Temporary Clinic Address: 400 Woodlawn Road Aliquippa PA

~~Temporary Clinic Telephone: (724-857-9640)~~ ~~Temporary~~ Clinic Facsimile #: (724-857-9653)

Contact Staff Person(s): (Nursing department) _____

Temporary Clinic Hours:M-F 5-11am Sat 6-9a_Temporary Clinic Med Hours: M-F 5-11am Sat 6-9a

Cost: Please have your insurance card present at the time of guest dose

Medical Physician's Signature: _____ **Date Signed:** _____

Authorization to Release Information

Patient Name	Date of Birth	Social Security Number
Address		

The above-named individual (or his/her legally authorized representative named below) authorizes and requests:

Name of Pinnacle Provider Entity:
PTSA
Address of Pinnacle Provider Entity:
400 Woodlawn Road Aliquippa PA 15001 P: 724-857-9640 Fax: 724 857-9653

the above-named provider to disclose and furnish the information requested below to the following person or organization:

Name of Person or Organization Information is to be sent to:
Gateway Rehabilitation Center - Main Campus
Address:
100 Moffett Run Road Aliquippa PA 15001

The information to be disclosed includes the following [**check** all that apply]:

- ☒ 1. Whether the client is or is not in treatment
- ☒ 2. The prognosis of the client
- ☒ 3. The nature of the project
- ☒ 4. A brief description of the progress of the client
- ☒ 5. A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse
- ☐ 6. All Billing Records (Statements/Bills/Insurance Claim Forms, etc.).
- ☐ 7. AIDS/HIV/Related Illness Information.
- ☐ 8. Psychotherapy/counseling notes
- ☒ 9. Other (explain): Admission date

The date(s) of treatment/services to be released include: admission to discharge

The purpose of the disclosure of the foregoing information is: Coordination of care

My authorization to release the foregoing information expires [insert a date, event or condition]: discharge

I understand the following:

1. This authorization may be revoked by me at any time in writing and/or verbally (such action verified in writing), except to the extent the above-named Pinnacle Provider Entity has already acted in reliance on this authorization. Acting in reliance includes, but is not limited to, the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
2. The Pinnacle Provider Entity cannot condition treatment on the signing of this authorization.
3. I have the right to inspect or receive a copy of the information sought to be disclosed or disclosed in this authorization as permitted under HIPAA and other applicable laws and regulations.
4. By signing this form, I am authorizing the Pinnacle Provider Entity named above to release and disclose information as described in this authorization.
5. A disclosure made by the above-named Pinnacle Provider Entity pursuant to this authorization will contain the written statement attached to this authorization
6. Information released to judges, probation or parole officers, insurance companies, health or hospital plan, or government official, under Pa.Code 255.5(1), (2), (4), (7), or (8) shall be restricted to the enumerated categories set forth in 1-5 above.

I ☐ ACCEPT ☒ DECLINE a copy of this form.

Notice Accompanying Disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release 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 Name:_____

Patient Signature:_____ Date: _____

Witness Name:_____

Witness Signature:_____ Date:_____

Authorization to Release Information

Patient Name	Date of Birth	Social Security Number
Address		

The above-named individual (or his/her legally authorized representative named below) authorizes and requests:

Name of Pinnacle Provider Entity:
Gateway Rehabilitation Center - Main Campus
Address of Pinnacle Provider Entity:
Run Road 100 Moffett Run road Aliquippa PA 15001

the above-named provider to disclose and furnish the information requested below to the following person or organization:

Name of Person or Organization Information is to be sent to:
PTSA
Address:
400 Woodlawn Road Aliquippa PA 15001

The information to be disclosed includes the following [**check** all that apply]:

☒ 1. Whether the client is or is not in treatment

☒ 2. The prognosis of the client

☒ 3. The nature of the project

☒ 4. A brief description of the progress of the client

☒ 5. A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse

☐ 6. All Billing Records (Statements/Bills/Insurance Claim Forms, etc.).

☐ 7. AIDS/HIV/Related Illness Information.

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Patient Name:_____

Patient Signature:_____ Date: _____

Witness Name:_____

Witness Signature:_____ Date:_____