Welcome,

Gateway Rehabilitation Center has partnered with Pinnacle Treatment Centers of Aliquippa to assist with medication needs while attending inpatient treatment services. Prior to admission, Pinnacle will need the following information (please use attached forms):

- Release of information (2 way) from the home clinic to Pinnacle.
- Release of information (2 way) from the home clinic to Gateway.
- Release of information (2 way) for Pinnacle and Gateway.
- Letter guaranteeing return, once discharged from Gateway.
- Scanned copy of valid photo ID (must have this present for dosing).
- Copy of all insurance cards (front and back).

Once all forms, ID, and insurance card(s) are collected, please fax to Pinnacle Treatment Services directly at 724-857-9653 or securely send via email to PTSAguestdosing@pinnacletreatment.com. Please also send the entire Welcome Packet to Gateway Rehab Center, by either fax at 724-375-3878 or securely send via email to gatewaycas@gatewayrehab.org.

For any further inquiries, please contact us at:

Gateway Rehabilitation Center
100 Moffett Run Road
Aliquippa PA 15001
724-378-4461 x2444

Pinnacle Treatment Services of Aliquippa
400 Woodlawn Road
Aliquippa PA 15001
724-857-9640

Thank you.

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.

☐ 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.
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Patient Name:____________________________________

Patient Signature:________________________________ Date: ______________

Witness Name:___________________________________

Witness Signature:________________________________ Date:_______________

Pinnacle Treatment Centers
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:
One Hospital Drive 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:
Home Clinic:
Address:
Home Clinic Address:

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): dosing records, methadone dosage, last dose received

The date(s) of treatment/services to be released include: Admission to Discharge

The purpose of the disclosure of the foregoing information is: Coordination for Gateway Rehab

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.
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Patient Name:____________________________________

Patient Signature:________________________________ Date: ______________

Witness Name:___________________________________

Witness Signature:________________________________ Date:_______________

Pinnacle Treatment Centers
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:
Home Clinic:
Address of Pinnacle Provider Entity:
Home Clinic Address:

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:
One Hospital Drive Aliquippa PA 15001 Phone: 7248579640 Fax: 7248579653

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): dosing records, methadone dosage, last dose received

The date(s) of treatment/services to be released include: Admission to Discharge

The purpose of the disclosure of the foregoing information is: Coordination for Gateway Rehab

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.
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Patient Name:____________________________________

Patient Signature:_________________________________ Date: ______________

Witness Name:___________________________________

Witness Signature:________________________________ Date:_______________

Pinnacle Treatment Centers
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: 100 Moffett Run Rd 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: Home clinic:
Address: Home clinic address:

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): ______________________

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.
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Patient Name:______________________________

Patient Signature:___________________________ Date: ____________

Witness Name:______________________________

Witness Signature:___________________________ Date:_____________

Pinnacle Treatment Centers
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: Home clinic:
Address of Pinnacle Provider Entity: Home clinic address:

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 Rd 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): ______________________________

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:

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Patient Name:____________________________________

Patient Signature:________________________________ Date: ______________

Witness Name:___________________________________

Witness Signature:________________________________ Date:_______________