PSYCHIATRIC REHABILITATION PROGRAM

CONSENT OF PARTICIPATION IN THERAPEUTIC SERVICES [ADULT]

I, _____, agree to participate in the Psychiatric
(Client's Name)

Rehabilitation Program. I hereby give consent for the services to be provided.

I have been informed of the services that will be rendered to include but not limited to:

- Independent Living Skills
- Self Care Skills
- Mobility and Transportation Skills
- Employment Training
- Money Management

I have been offered _____On-Site _____Off-Site _____Both

ACKNOWLEDGEMENT OF RECEIPT OF HANDBOOK

- Notice of Privacy Practices and Confidentiality Agreement
- Explanation of Mental Health Procedures
- Consent and Authorization for Electronic Communication
- Notice of Rights and Responsibilities
- Complaint Policy and Procedure
- Crisis Management Information
- Emergency Evacuation Procedures
- Discharge, Transition, and Referrals Procedure
- Fees and Financial Obligations
-

Please initial, in the box, acknowledging that you have read, received and agreed to the above information, located in the client handbook.

_____ _____

Client/Parent/Guardian Signature (Please Circle One) **Date**

_____ _____

Client/Parent/Guardian Name (Please Print) **Date**

_____ _____

ITS Staff Signature **Date**

CLIENT INTAKE

Referral Date: _____ Referral Source: _____

Mr/Mrs/Ms/Miss / Client Name: _____ Client DOB: _____

Client Social Security #: _____-____-_____ Medical Assistance # (If Applicable): _____

Address: _____, _____, _____, _____
Street City State Zip

Phone: (Cell) _____ (Home) _____ (E-mail) _____

☐ *Please place a checkmark in the box if you currently do not have a primary care doctor; however, you will inform ITS when a PCP is attained.*

Primary Care Doctor: _____ _____
Name Phone Number

Address: _____, _____, _____, _____
Street City State Zip

Case Manager (If Applicable): _____ _____
Name Phone Number

Primary Insurance Carrier's Information

Name: _____ DOB: _____ Insurance Customer Service #: _____

Member ID Number: _____ Group Number (if applicable): _____

Emergency Contacts *(Please provide information for those who may be contacted in case of an emergency):*

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

☐ *Please place a checkmark in the box if you do not have a second emergency contact.*

If client is a minor, please complete a third emergency contact.

*Name: _____

Address: _____

Phone Number: _____

☐ *Please place a checkmark in the box if you do not have a third emergency contact.*

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Our Privacy Practices: Innovative Therapeutic Services, CORP (ITS) promises to maintain the confidentiality of your protected health information (PHI). PHI is health information about you that we have in our records. We will not share this information, in whole or in part, with any person or entity without your consent. In addition, we commit to delivering our services in a manner that maintains confidentiality. We will coordinate services with primary care physicians, referring agencies, schools or other stakeholders with your written consent.

Federal & State Laws: We are required by federal regulations called the "HIPAA Privacy Regulations" to protect the confidentiality of your health information. We are also required to comply with state laws that are often more stringent than the federal regulations. This, in essence, gives you double protection.

Authorization to Disclose PHI: It is our practice to obtain your authorization or consent before we disclose your PHI to another person or entity. You may revoke your authorization or consent at any time and for any reason.

How We Use Your Protected Health Information: We use your PHI solely for treatment, payment and health care operations. For example, we may use your PHI to plan and provide your care and treatment; communicate with health care professionals; obtain payment for our services; educate and train our staff; and assess and improve our services. We are also permitted to use or disclose your health information if required by law.

Your Rights: You have a right to request a restriction on certain uses and disclosures of your PHI; inspect and copy your PHI; request amendments to your PHI; and obtain an accounting or list of disclosures of your PHI. This access does not include records from outside agencies, such as hospitals, DOR, etc. Such access to the file must be authorized by the Program Director, with a notation of date and time entered in the file. If it is felt that, it would not be in the best interest of the member to access the file, a written summary of the file contents will be provided to the individual. A staff member must be present while the record is being reviewed by the member to ensure that nothing is removed or changed within the file contents. A member who disagrees with the contents of his/her records will have the opportunity to submit corrections/amendments, which would be included in the records.

Research: No sessions will be recorded without the written consent of the client. No information will be reviewed for research without the written consent of the client.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages text messages, emails postcards, or letters).

Our Duty: It is our duty to provide you with a copy of this disclosure statement for your personal records at the point of intake. A duplicate can be provided for you at any time upon request. With few exceptions, our conversations are confidential. State law, federal regulations and our code of ethics specifically guarantee this confidentiality. There are some situations, however, in which confidentiality cannot be guaranteed.

They fall within the following categories:

- We must notify appropriate persons if we feel you may harm another individual.
- We must report any occurrence of child abuse (past or present), or the abuse, neglect or exploitation of the elderly.
- We will have to respond to a subpoena accompanied by a court order.
- We will have to respond to any situation in which we believe you may harm yourself.

CLIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

CLIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Client Name: _____ **Date of Birth**: _____

- I,_____, acknowledge that I have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

- I,_____, consent to the use and disclosure of my personal health information by your office for Treatment, Billing / Payment and Health care operations as outlined in the NOTICE OF PRIVACY PRACTICES.

_____ _____
Client/Parent/Guardian Signature **Date**

_____ _____
Print Name (If not signed by client) **Date**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the Undersigned, authorize: **Innovative Therapeutic Services** and staff members to release and receive written and/or verbal information related to the client listed to the person or agency indicated below:

Client Name: _____ **Date of Birth**: _____

Once completed and signed, this authorization will remain in effect until: _____
(one year from date signed)

The Mental Health Information Authorized for Release includes: (Please check all that apply)

☐ Copies of Records ☐ Discharge Summaries ☐ Consultation

☐ Immunization Records ☐ Other Information: _____

Person/Organization authorized to receive your information:

Primary Care Doctor (PCP): _____

Address: _____

Phone #: _____ Fax #: _____

Purpose of Release: Coordination of Care_____

☐ **I currently do not have a primary care doctor; however, I will inform ITS when a PCP is attained.** ***Please sign below.***

☐ **I do not wish to have ANY information released to the client's primary care doctor (PCP).** ***Please sign below.***

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I acknowledge that the information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I specifically authorize the release of confidential information relating to drug and/or alcohol abuse, psychiatric, HIV results and or AIDS information. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR 2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Client/Parent/Guardian Signature **Date**

_____ _____

Print Name **Date**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the Undersigned, authorize: **Innovative Therapeutic Services** and staff members to release and receive written and/or verbal information related to the client listed to the person or agency indicated below:

Client Name: _____ **Date of Birth**: _____

Once completed and signed, this authorization will remain in effect until: _____
(one year from date signed)

The Mental Health Information Authorized for Release includes: (Please check all that apply)

☐ Copies of Records ☐ Discharge Summaries ☐ Consultation

☐ School Visitation ☐ Immunization Records

☐ Psychiatric Records ☐ Other Information: _____

☐ Other Information: _____

Person/Organization authorized to receive your information:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose of Release: Coordination of Care_____

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

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_____ _____

Client/Parent/Guardian Signature **Date**

_____ _____

Print Name Date

CRISIS MANAGEMENT PLAN (ADULT)

Client's Name: _____

Crisis is a sudden change in the client 's behavior in response to stress or other painful feelings. It is often negative due to the client's lack of experience or inability to cope with personal or inter-personal problems. The goals of **crisis management** are to: provide immediate emotional support and reduce stress, decrease the risk of harm to the client or others and teach more constructive ways for dealing with stress or other painful feelings. Part of good crisis management is knowing what to expect. Generally, a person's response to stress or negative situations is the same. With that in mind, check the responses that relate to you.

When I am upset, I typically: _____.

1. ____ Use profanity (ie: cursing, swearing, vulgar language)
2. ____ Makes verbal or physical threats (ie: violating personal space)
3. ____ Has a rage reaction (ie: temper tantrum, screaming, door slamming)
4. ____ Tries to hurt others (ie: hits, kicks, bites, spits, pushes, etc.)
5. ____ Tries to hurt himself/herself
6. ____ Destroys property
7. ____ Makes bad decisions
8. ____ Uses drugs or alcohol
9. ____ Seeks out weapons or other harmful objects
10. ____ Targets or starts fights or arguments with others
11. ____ Demands to be left alone/isolates
12. ____ Makes homicidal threats ("I'm going to kill____.")
13. ____ Makes suicidal threats ("I'm going to kill myself.")

Other: _____.

TIPS for how to safely manage a crisis:

1. **___ Take a deep breath and recognize crisis by putting into prospective.**
2. **___ Try to control my behavior to harm self/others by taking a personal "time-out."**
3. **___ Avoid drugs or alcohol.**
4. **___ Avoid use of all weapons.**
5. **___ Avoid threats/altercations with others by walking away from upsetting situations.**
6. **___ Call your Social Support Partner (SSP) or emergency contact person:**
   Name: _____ Phone #:_____
7. **___ Call your PRP coordinator or primary therapist (during business hours).**
8. **___ Call the ITS crisis line: 301-604-1458 (after business hours).**
9. **___ Other: _____**

If my crisis has not been resolved after following the actions above, I agree to:

1. Call a 24-hr crisis hotline City/410-931-2214 County/410-435-5717
2. Go to nearest Hospital Emergency Room
3. Call 911

If/when I call my PRP coordinator or primary therapist (during normal business hours) they may:

1. Assess my crisis and attempt to assist me in resolution via phone.
2. If available, my PRP coordinator may transport me to nearest hospital. If my PRP counselor is unavailable, my PRP coordinator or therapist will contact my SSP and/or emergency contact person to transport me to ER.
3. Call 911 on my behalf.
4. Discuss my crisis and medication with psychiatrist on staff.

Client Signature: _____ Date: _____

ITS Staff Signature: _____ Date: _____

CASE MANAGEMENT ENTITLEMENT AND ASSESSMENT

Name of Client _____ **Date** _____

Use this checklist as a prompt for assessing client needs.

Immediate/crisis needs
- ☐ Accommodation
- ☐ Security
- ☐ Clothing
- ☐ Food
- ☐ Housing
- ☐ Medical
- ☐ Legal
- ☐ Financial/income support
- ☐ Transportation

Health
- ☐ Physical health, sickness or injury
- ☐ Primary care physician
- ☐ Mental health issues
- ☐ Sexual assault issues
- ☐ Domestic violence issues
- ☐ Drug/alcohol issues

Health information
- ☐ Contraception
- ☐ Safe sex
- ☐ Women's health
- ☐ Drugs
- ☐ Other

Living skills
- ☐ Parenting skills
- ☐ Child care issues
- ☐ Family issues
- ☐ Budget/income
- ☐ Employment skills
- ☐ Activities of daily living
- ☐ Support groups

Education
- ☐ Employment
- ☐ Training programs (i.e. vocational, rehabilitation, GED, adult ed.)
- ☐ Education
  - numeracy
  - literacy
  - registered in school

Legal issues
- ☐ Court support
- ☐ Domestic issues (restraining order)
- ☐ Any involvement with the police
- ☐ Custody
- ☐ Guardianship/wardship
- ☐ Other

☐ **Special Religious or Cultural Needs**

Entitlements
- ☐ Disability
- ☐ Active Medical Assistance

*** Please asterisk the priority needs and provide explanation of those needs in detail.**

_____

_____

_____

_____

_____

ITS STAFF SIGNATURE

ADVANCED MENTAL HEALTH DIRECTIVES
(Applicable if Age 16 or Older)

What is an Advance Directive?

An advance directive outlines a person's wishes in the event that he or she is incapacitated or unable to express wishes for health care and treatments. Under federal law, any facility receiving Medicare or Medicaid reimbursements is required to use advance directives. Individuals with a physical and behavioral health illness are covered under this mandate.

Behavioral Health Advance Directive

In a behavioral health advance directive, people are able to express their preferences on where to receive care and what treatments they are willing to undergo. They are also able to identify an agent or representative who is trusted and legally empowered to make healthcare decisions on their behalf. These decisions may include the use of all or certain medications, preferred facilities, and listings of visitors allowed in facility-based care. Advance directive laws may vary across states. Therefore, it is important to be sure that any advance directive form meets the requirements of a given state.

Citation: https://www.samhsa.gov/section-223/governance-oversight/directives-behavioral-health

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_____ _____

Client Printed Name **Date of Birth**

- **I currently have an Advance Mental Health Directive and have provided ITS a copy.**

  ☐ Yes ☐ No

- **I do not have an Advance Mental Health Directive.**

  ☐ Yes ☐ No

- **I would like more information about the Advance Mental Health Directive.**

  (If yes is checked, the client will receive a copy on how to start an Advance Mental Health Directive during today's session.)

  ☐ Yes ☐ No

- ☐ **If you are under the age of 16, please place a check mark in the box as this does not applicable to you.**

I understand that I may provide ITS with an updated copy of my Advance Mental Health Directive or request information about the Advance Mental Health Directive at anytime.

_____ _____

Client Signature (Age 16 or older) **Date**

_____ _____

Parent/Guardian Signature (if applicable) **Date**

_____ _____

ITS Staff Signature Date