innovative
therapeutic services

Outpatient Mental Health Clinic (OMHC) – Adults

Client Intake

Client Name: _____ Client DOB: _____

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

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

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

Preferred Language:

☐ English
☐ Spanish
☐ American Sign Language (ASL)
☐ Other: _____

Preferred Method of Communication (Please check all that apply):

☐ Email
☐ Phone (Call)
☐ Phone (Text Message)

□ *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): _____

If the Financial Responsible Party differs from the Primary Insurance Holder/Guarantor, please list their First Name, Last Name, and Phone Number below:

Name: _____ Phone Number: _____

Emergency Contact & Crisis Management Plan

A 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 better, 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.

If a client is experiencing a crisis the following steps will be taken in this order:
ITS staff will:

1. Assess for suicidal or homicidal ideation, plan and intent.
2. Contact a ITS supervisor or Clinical or PRP Director to provide guidance and support to the ITS staff person.
3. Contact the client's designated emergency contact(s) listed below.
4. Report the incident to the client's psychiatrist (if applicable) and document the incident in the client's chart.

If the client is a danger to him/herself or others, ITS staff will:

1. Assess for suicidal or homicidal ideation, plan and intent.
2. Contact an ITS supervisor or Clinical or PRP Director to provide guidance and support to the ITS staff person.
3. Contact the client's designated emergency contact(s) listed below.
4. Contact mobile crisis or 911.
5. Follow the client to the emergency room.
6. Report the incident to the client's psychiatrist (if applicable) and document the incident in the client's chart.

Emergency Contact #1 Name: _____

Address: _____

☐ Please check if the address is unknown.

Phone Number: _____ Relation to Client: _____

Consent of Participation in Therapeutic Services

I, the undersigned agree to participate in therapy services.

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

- Individual Therapy
- Family/Couples Therapy
- Group Therapy
- Psychiatric/Medication Management Services

Electronic Signature Disclosure and Consent

Overview

This Electronic Signature (E-Signature) Disclosure and Consent sets forth the terms and conditions governing my consent to sign documents electronically through, and my use of, Innovative Therapeutic Services, Corp. (ITS) Electronic Signature System through our electronic medical records system. I may decline to electronically sign any document by verbally informing the ITS administrative staff. I acknowledge that declining to electronically sign or complete any document will require me to complete a paper copy of any documents ITS may need on file.

Effect of My Consent

I understand that electronically signing and submitting any document(s) to Innovative Therapeutic Services, Corp. (ITS) legally binds me in the same manner as if I had signed in a non-electronic form, and the electronically stored copy of my signature, any written instruction or authorization and any other document provided to me by ITS, is considered to be the true, accurate and complete record, legally enforceable in any proceeding to the same extent as if such documents were originally generated and maintained in printed form. I agree not to contest the admissibility or enforceability of ITS electronically stored copy of this Consent and any other documents.

By using the System to electronically sign and submit any document, I agree to the terms and conditions of this Consent.

Notice of Privacy Practices for Protected Health Information (HIPAA)

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 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 the 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 and Consent of the Notice of Privacy Practices for Protected Health Information

By signing, 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.

If you consent, please check the **"DO"** field below.

If you **DO NOT** consent, please check the **"DO NOT"** field below.

- ☐ I do consent.
- ☐ I do not consent.

Fees and Financial Obligations:

Prior to consenting to treatment Innovative Therapeutic Services (ITS) will discuss the estimated cost of payment and payment options with the client. ITS billing policy states that if a client does not have insurance coverage, the client may be billed by Innovative Therapeutic Services, CORP. For clients with insurance, services will be billed by Innovative Therapeutic Services through the client's insurance company. It is the client's responsibility to know their insurance benefits and whether or not the services they are to receive are covered benefits. The client will be responsible for any co-pay or balance due that Innovative Therapeutic Services is unable to collect from the insurance carrier for whatever reason. If there is a copay, copays are collected at the time of service.

Medicaid clients are exempt from any financial obligations to Innovative Therapeutic Services.
Medicaid recipients will not be billed for any missed appointments and will not be charged for any services.

Fees and Co-Payments/Co-Insurances/Deductibles for Privately Insured Clients:
Privately insured clients are responsible for paying all fees and/or co-payments prior to initial and subsequent therapeutic sessions (e.g., individual therapy, group therapy, couples therapy, etc.). Clients are required to satisfy each co-payment *prior to the scheduled appointment*. Failure to pay all fees and/or co-payments will result in ITS canceling subsequent appointments until all fees and/or co-payments are satisfied. Privately insured clients are responsible for updating ITS staff if there are any changes to their address, phone number, and insurance information prior to the scheduled appointment. ITS reserves the right to verify the client's insurance information and will notify the clients of fees and/or co-payment due *prior to the scheduled appointment.* ITS also reserves the right to send the client an invoice for outstanding fees and/or co-payments to the client's provided address.

Cancellations and Missed Appointments:
Innovative Therapeutic Services Corp. (ITS) understands that situations arise in which you must cancel your appointment. Our practice firmly believes that a good provider and client relationship is based on understanding, good communication, and accountability.

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the $50.00 fee if cancellation is less than 24 hours.

There is a 15-minute grace period for each session, after which, the session will be deemed a no-show and will result in a $50.00 fee. Due to HIPAA regulations, privacy, and confidentiality, client sessions must take place in a confidential and quiet therapeutic space. If the client's location is not suitable for therapy, the session will end and be marked as a late cancellation and charged a $50.00 fee.

***Please note: The $50.00 fee only applies to clients who are Self-Pay/Out-of-Pocket, Sliding Scale, and/or have Private/Commercial insurance. This fee must be satisfied prior to resuming services.**

Clients are responsible for keeping all scheduled appointments. We utilize an electronic management record system that generates calls, texts, and/or email reminders of upcoming appointments. Session reminders are courtesy of the practice but are the responsibility of the client. Concessions will not be made for missed sessions due to the lack of appointment reminders sent from the system.

A $50.00 service charge will be charged for any checks returned for any reason for special handling.

Despite insurance deductible, co-payment, or co-insurance amount, a less than 24-hour cancellation and no-call, no-show, is not covered by the insurance and will be charged a $50.00 fee. Clients will be charged 24 hours after the session should have taken place.

Again, cancellations and the re-scheduled session will be subject to a $50.00 fee if **NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE.** This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

Clients with deductibles will be responsible for the insurance contracted rate that ITS has with their insurance provider until the deductible is met. At that time, all co-payment and co-insurance amounts will apply. Your intake session and standard session costs will be discussed with you at the time you schedule your session.

- **Therapy/PRP:** Two late cancellations or no-shows in a row or within a 30-day period will result in being discharged from services and referrals to outside providers being provided.

- **Psychiatry/Medication Management:** Two late cancellations or no-shows in a row or within a 60-day period will result in being discharged from services and referrals to outside providers being provided.

If a client would like to return for services they may do so after 30 days by calling the office, understanding that the former provider may not have availability.

In order to remain active in therapy, an individual must be seen once every 30 days. The only exception to this is a planned absence (such as an extended vacation out of state) or other highly unusual circumstances (hospitalization, incarceration) and this information has been communicated with the treating clinician.

Court Appearance/Subpoena Fees:

The minimum charge for a court appearance: $1500.00 USD.

The rate of $500.00 USD per hour - (additional charges will incur if court is more than 3 hours).

A retainer of $1500.00 USD is due a month in advance from the scheduled court date. Payment may be submitted via money order, cashier's/official/bank check, and/or using a debit/credit card.

If a subpoena or notice to meet attorney(s) is received without a minimum of a 2-week notice, there will be an additional $250.00 USD "express" charge.

If the case is reset with less than 1 weeks' notice, then the client will be charged $500.00 USD (in addition to the minimum retainer of $1500 plus $500 for every additional hour over 3 hours).

Documentation and Records Requests Fees

Documentation Requests:

- Clients must be established for a minimum of 6 months prior to requesting the completion of documentation or request letters of recommendation.
- All documentation requests and recommendations will be processed within 14 business days, at the discretion of the client's provider(s).
- If applicable, please complete demographic information (name, date of birth, address, phone number, etc.) ahead of time to minimize delay in processing time.

Document/Form Type	**Cost**
School/Work Excuse	$0.00
Letter of Participation *Includes dates of attendance, diagnosis, active/inactive status, and provider(s) seen.	$0.00
Medication Administered at School Form **Clients must provide forms with the demographics completed for the provider.*	$0.00
Short-term/Long-term Disability Forms/FMLA Forms **Clients must provide forms with the demographics completed for the provider.*	$30.00 for up to 5 pages. ***Additional $5.00 per page thereafter.**
Letter of Recommendation (Ex: Emotional support animals, service animals, accommodations for testing, IEP/504)	$30.00
Miscellaneous (If a form/letter is not listed, it is subject to review by your provider to determine if there will be a fee)	To be determined.

Records Requests:

- Records requests will be completed within 14 business days once the request has been received.
- Only documents generated by Innovative Therapeutic Services Corp. (ITS), will be released.
- Once your records have been completed, a staff member will contact you with an update.

Description	**Cost**
Preparation Fee *Applicable **ONLY** if the records are sent to a provider or a person other than the client or the client's personal representative.	$22.88
Postage and Handling *Applicable **ONLY** when a client is requesting the records be mailed to their residence or provider's office.	$15.00
Copies of Records sent electronically (via fax) or uploaded via secured government platforms. Base Fee (from 1 to 50 pages) 50 or more pages *Applicable **ONLY** if the records are sent to a provider or a person other than the client or the client's personal representative.	 $15.00 $0.57/page
Copies of Records (Paper Copy/Printed) Base Fee (from 1 to 50 pages) 50 or more pages *Applicable **ONLY** if the records are sent to a provider or a person other than the client or the client's personal representative.	 $15.00 $0.76/page

*Clients and/or their personal representatives (Power of Attorney/Legal Guardian) are not subject to any ***Records Requests*** fees outlined above when requesting records on their own behalf.
Clients with Maryland Medicaid are not subject to any ***Records Requests* fees outlined above.
***All terms and fees are subject to change at any time. ITS will notify clients immediately if any changes occur.

Informed Consent for Telemedicine/Telehealth Services

INTRODUCTION
Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include therapists, PRP coordinators, psychiatrists, and/or psychiatric nurse practitioners. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. HIPAA compliant be used unless permitted otherwise by the state or federal level.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining the expertise of a distant specialist.

POSSIBLE RISKS
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions, or other judgment errors.

BY SIGNING, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect the privacy and the confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine that identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time. Innovative Therapeutic Services has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Innovative Therapeutic Services of electronic interactions regarding the care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE
I have read and understood the information provided above regarding telemedicine, have discussed it with my therapist, PRP coordinator, psychiatrist, psychiatric nurse practitioner, or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Innovative Therapeutic Services to use telemedicine in the course of my diagnosis and treatment.

Treatment with Intern Informed Consent Form

- I understand that my child, my family, or myself will be receiving therapy services from a student intern who is under the supervision of Innovative Therapeutic Services, Corp. (ITS) licensed social worker or professional counselor and the field placement office of their educational institution.

- Student interns are bound by the ethical guidelines of their profession and adhere to the guidelines specified by the ITS service agreement, telehealth service consent, internship supervision agreement of their educational institution, and Notice of Privacy/HIPAA.

- Student interns have completed most master's level education from their educational institution in their field of study, have demonstrated core competencies, and have been determined by their educational institution as ready to apply his or her clinical skills to work with clients.

- Student interns receive intensive ongoing guidance, evaluation, and education in providing excellence in clinical skills to you and your family members. By working with a student intern, each client receives the benefit of a clinically experienced supervision team assisting in assessment and treatment planning to address concerns in therapy.

- Student interns may provide counseling sessions in conjunction with a fully licensed clinician, and when deemed ready by ITS, will provide counseling sessions without a supervising clinician present.

- Clients may terminate this agreement at any time, but termination of this agreement will require a transfer to another provider.

I, the client or his/her/they legal, custodial parent, or legal guardian, acknowledge that I am voluntarily authorizing treatment for myself or my child/ward at ITS treatment to be conducted by a student intern. I have been informed of the purpose of the treatment, and the services which may be provided.

Psychiatry/Medication Management Policy

- Clients who are more than 10 minutes late for 30-minute follow-up appointments have deemed a no-show. Clients who are more than 15 minutes late for 45–60-minute appointments have deemed a no-show. We will make every effort to reschedule your appointment in a timely manner. Please understand that your provider may not be able to see you on the same day.
- Clients must make every effort to attend their scheduled follow-up appointments to ensure compliance with their medication management treatment. Clients who miss their appointments due to client cancellation, client rescheduling, and/or client no-show, will not receive a bridge of medication. Clients are advised to contact their primary care physician to request a refill until their next scheduled appointment.
- Clients must be established for a minimum of 6 months prior to requesting the completion of documentation or requests letters of recommendation. All documentation requests and recommendations will be processed within 14 business days, at the discretion of the psychiatrist or psychiatric nurse practitioner.
  Please complete demographic information (name, date of birth, address, phone number, etc.) ahead of time to minimize delay in processing time.
- Phone messages will be returned within 3-4 business days. If you need immediate assistance, please contact your primary care physician, or visit your local emergency room.
- Clients who are inactive in medication management for more than 6 months will be discharged from the medication management program. Should a client request to be reinstated into the ITS medication management program, they may contact the office to schedule an appointment. Clients may need to be reassessed or referred out to another psychiatric provider should ITS be unable to continue care.

If you are experiencing side effects that **you feel are concerning,** please contact your primary care physician or visit your local emergency room.

Authorization to Use and Disclosure Protected Health Information

I, the Undersigned, authorize: **Innovative Therapeutic Services (ITS)** 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 the 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: _____

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 (If not signed by client) **Date**

Advance Mental Health Directive
(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 checkmark the box as this does not apply 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 any time.

_____ _____

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

_____ _____

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

_____ _____

ITS Staff Signature Date

Outpatient Mental Health Clinic Receipt of Program Policies

By signing below, I acknowledge that I have read, understand, and agree to the policies of ITS' outpatient mental health treatment as defined in the policies outlined in the consent packet I have completed.

Those policies include:

- Consent of Participation in Therapeutic Services
- Electronic Signature Disclosure and Consent
- Notice of Privacy Practices for Protected Health Information (HIPAA)
- Policy on Financial Obligations
- Cancellation and Missed Appointments
- Informed Consent for Telemedicine/Telehealth Services
- Treatment with Intern Informed Consent Form
- Psychiatry/Medication Management Policy
- Emergency Contact & Crisis Management Plan
- Authorization to Use and Disclose Protected Health Information
- Advance Mental Health Directives
- Client Handbook

_____ _____

Client First and Last Name **Date of Birth**

_____ _____

Client/Parent/Legal Guardian Signature **Date**