CLIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE

**ALL**

PAPERWORK IN PACKET 1

**HOWEVER, PLEASE DO NOT**

**DATE ANY FORMS**

UNTIL YOU and/or THE CLIENT IS IN OUR OFFICE

TO COMPLETE THE CDA

(Comprehensive Diagnostic Assessment)

**Packet 1**

**MEDICAID / OPTUM Clients**

**Clinic, CBRS, TCM and Peer / Family Support Services**

* 1. Packet 1 signature page
* 2. Client & Crisis Information & Authorization for Medical Treatment Form
* 3. Financial Agreement
* 4. Client Rights and Responsibilities & HIPAA confirmation page
* 5. Informed Consent for CLINICAL, CBRS, TCM, & PEER SUPPORT SERVICES (PSS) signature page
* 6. Packet 2 Client Handbook Signature Page

* Symptom Checklist
* Release of Information for Emergency/Crisis Contact(s)
* Release of Information for Primary Care Physician
* Release of Information for Pharmacy
* Release of Information of Medication Manager
* Other Releases as Necessary

**\_\_ \*\* If Applicable, See Additional Downloadable Forms Available on our Website\*\*\_\_\_\_\_**

* Refusal to Sign Release Form
* Services to Children
* Wellness Assessment

\* I sign below, indicating that I have received and completed the above paperwork, as well as have been thoroughly informed of my rights and responsibilities. The documents listed above were explained and reviewed with me by a Pride Mental Health (PMH) staff member. My Signature indicates my receiving, reviewing and understanding of their contents. \*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Client Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_**

**Parent/Guardian Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_**

**PMH Staff Member Name (Print)** 1

**Client & Crisis Policy Information Form**

**Office Hours: Monday – Friday 9am to 6pm**

**Crisis Phone Numbers:**

**Optum Crisis Line (available 24/7): 1.855.202.0973**

**Idaho Suicide/Crisis Line (available 24/7): 208.398.4357**

**National Suicide Prevention Line: 1.800.273.8255**

**Nationwide Crisis Text Line (Text Only – 24/7): 741741**

\* If you have a medical emergency, are planning to hurt yourself or someone else, or you are being abused, please **call 911** **immediately**. \*

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Ph. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Client MH Diagnosis (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Need a RELEASE of INFORMATION form completed & signed for all Emergency Contacts \***

Reason Seeking Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Primary Physician Information**

Physician Name and Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

2a

List all Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All Known Allergies & Adverse Reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any type of Infectious Diseases? 🞏Yes 🞏No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services You Are Currently Receiving from Other Agencies**

**(Provide name of facility & of all service providers)**

Intensive Behavioral Therapy (IBT): 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counseling/Psychiatrist: 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Therapy (DT): 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CBRS: 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peer or Family Support 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TCM: 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Manager: 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Therapy: 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vocational Rehabilitation: 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug or Alcohol: Type\_\_\_\_\_\_\_\_\_\_ 🞏Yes 🞏No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need special accommodation? If yes please list and notify the front office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2b

**Pride Mental Health documents all calls in crisis log as well as notifies/collaborates with client’s other Pride Mental Health’s service providers (such as the CBRS/TCM/PSS worker and/or Clinician) to allow for consistent care, communication, and support from and between all Intensive Day Treatment members to prevent any type of sentinel events from occurring in the future.**

**Authorization for Medical Treatment**

Pride Mental Health and its Employees have permission to seek medical treatment for me and/or my child if something should occur that results in immediate medical attention.

I have received, read, been informed, have had an opportunity to ask questions I may have, and fully understand Pride Mental Health’s crisis phone line policy.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Client Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Parent/Guardian Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

2c

**FINANCIAL AGREEMENT**

* I understand that my private pay fee is $85.00 to $150 per counseling session OR the discounted fee of \_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I understand that my Insurance Company determines the co-pay I will pay, as well as any out-of-pocket expenses that are required to meet my deductible/coinsurance.
* I understand that Pride Mental Health will follow any guidelines provided by my insurance company and any charges I incur are based on my Insurance Company’s Guidelines.
* I understand that if my Insurance Company doesn’t pay for services rendered I am ultimately responsible for the balance I accrue.
* I understand that I may be charged a **No-Show fee of $25.00** for missed appointments.
* I understand that if my health insurance is Medicaid I understand that there are no fees for services but I may still be charged a **No-Show fee of $25.00** for missed appointments.

I understand that Pride Mental Health will turn unpaid bills over to a collection agency for collection, which will include interest that has accrued. I understand that my private records will be provided to collection agencies which is allowed by HIPAA.

* Pride Mental Health charges a **minimum of** **$35.00** for LETTERS requested, which will be collected before the letter is produced.
* I understand that there is a **minimum charge of $20.00** per 15 minutes for any **telephone consultation** requested.
* I understand that there is a **minimum charge of $15.00** for **form completion on my behalf,** which includes any forms requested bylawyers, Department of Health and Welfare, Disability Determination etc.
* I understand that there is a **minimum charge of $25.00 for collection and faxing of documents,** which includes any forms requested by lawyers, Department of Health and Welfare, Disability Determination etc.

**Hours of Operation**

Pride Mental Health business hours are Monday through Friday from 9:00am to 6:00pm. If you are experiencing a crisis after hours (including the weekend you can call **Optum Crisis Line (Protocol) at 855-202-0973**; or **if you are in immediate danger dial 911.**

I have read, understand and agree to the contents of this document.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Client Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Parent/Guardian Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

3

**CLIENT RIGHTS AND RESPONSIBILITIES**

**I acknowledge that I understand and received a copy of this policy in my Client Handbook and was made aware, by Pride Mental Health staff, that this document is also**

**posted in the waiting area.**

**Additionally, I understand that I may request a copy of this document at any time.**

**HIPAA**

**NOTICE OF PRIVACY PRACTICES AND INFORMATION RIGHTS**

**IMPORTANT:**

**YOU HAVE BEEN PROVIDED WITH THIS DOCUMENT IN ITS ENTIRITY IN YOUR CLIENT HANDBOOK. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; YOUR RIGHTS AS A CONSUMER, AND HOW YOU CAN OBTAIN ACCESS TO YOUR RECORDS.**

**PLEASE REVIEW CAREFULLY**.

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of the Notice of Privacy Practices and Information Rights. I also understand and acknowledge the document’s importance to my care. If I have any questions regarding this form, I know that I can contact any Pride Mental Health staff, including the owner and operator, Dane M. Mullen.**

**(By signing below, you also acknowledge that you have read this document in its entirety that was provided to you at intake and understand the contents of this document.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Client Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_**

**Parent/Guardian Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

4

**Informed Consent for Clinical Services**

**By signing you agree that you were informed of the services offered, were alerted to the benefits and risks associated with counseling and received the document Informed Consent for Clinical Services in your handbook.**

**By signing this, you also agree to work with your counselor through the creation of a strictly professional counselor/client relationship, which will never be sexual in nature, to establish and commit to achieving goals you wish to accomplish. Goals will be accomplished through consistent attendance at counseling appointments as well as through your commitment in following treatment recommendations as indicated in your treatment plan and as instructed by your counselor.**

**Informed Consent for**

**CBRS, TCM and Peer Support Services (PSS)**

**By signing this Informed Consent for CBRS, TCM and CPS Services, I attest that I received this document in full and understand its contents. I or my child also agrees to work with my Pride Mental Health, CBR, TCM and CPS service provider(s) to establish and commit to work toward achieving goals (of my choosing) through creation of a professional, effective, and appropriate service provider/client relationship. I understand that these goals will be accomplished through consistent attendance to counseling and/or service provider appointments as well as through commitment in following treatment recommendations as indicated in my treatment plan(s) and as instructed by my counselor and service providers.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Client Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Parent/Guardian Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

5

**Packet 2**

**CLIENT HANDBOOK**

**MEDICAID / OPTUM Clients**

**Clinic, CBRS, TCM, and Peer Support Services (PSS)**

* 1. Mission Statement
* 2. HIPAA Long Form
* 3. Client Rights and Responsibilities
* 4. Informed Consent for Clinical Service
* 5. Informed Consent for CBRS / TCM / PSS
* 6. Pride Mental Health Ethics Policy
* 7. Policy and Procedures for Disruptive/Violent Individuals
* 8. Provider List for Mental Health Services
* 9. Advocacy Contact Information

**\* I sign below, clearly indicating that I have received the above documents. as well as have been thoroughly informed of my rights and responsibilities. The documents listed above were explained and reviewed with me by a Pride Mental Health staff member. My Signature indicates my receiving, reviewing and understanding of their contents. I acknowledge that I may refer to these forms, if I have questions or concerns. \***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Client Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**Parent/Guardian Name (Print)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_**

**PMH Staff Member Name (Print)**

6

**Symptom Checklist**

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Very worried to go out in public without someone

 It’s very hard to relate to others

 Do not like most people

 Excessively shy

 Communication problems

 Yells frequently

 Easily annoyed

 Hits Others

 Think about children in a sexual way

 Can’t pay attention

 Does things without thinking about consequences

 Hyper- causing school problems

 Won’t follow rules

 Gets angry quickly

 Avoids going to school/job

 Bullies others

 Breaks rules

 Cruel to animals

 Frequent fire setting

 Does not like to follow the rules of “authority”, i.e. teachers, boss, police, parent

 Extreme sadness in winter

 No desire to eat

 Over-eat most of the time

 Very afraid to be alone

Very upset when away from home or caregiver

 Not really attached to caregiver

Suicide attempt

 Injury to self, i.e. cutting, burning self, picking at self, pulling out hair

 Have a very hard time remembering things every day

 Drug use

 Alcohol use

 Intense surge of intense fear or worry that can cause heart to race, sweating, shortness of breath etc.

 Constant urges that cause handwashing a lot, checking the door lock a lot, repeating the same word several times, counting things etc.

 People are trying to deceive and betray you

 People often say they don’t understand what you mean

 Sadness

Cry frequently

 Always tired

 Thinks about killing self

 Frequent stomach aches

 Not sleeping at all for at least 2 days or more due to a lot of energy and you might buy things, use drugs or become very sexually active etc.

 Dislikes self a lot

 Feel little happiness

 People can read your mind

 Avoids people

 Avoid becoming too attached to friends or partner in fear of getting hurt

Afraid of things such as spiders, snakes, heights, colors, germs to the point of becoming “frozen”

 Can’t stop thinking about a lot of different things most of the day, which causes problems

 Can’t control emotions

 Terrified of getting a disease

 Can’t sleep very well

 Frequent nightmares

 Victim of rape, car wreck, abuse

 Witnessed abuse of another

 Thoughts of trauma occur without warning

 Excessive amount of energy for days without needing to sleep at all

 Don’t know how you ended up at a certain place (forgot)

 Excessively think about certain acts, spying on others that is sexual in nature

 Starve causing fast weight loss

 Eats a lot then throws up food

 Can predict future

 You know that people around you or on the T.V. or radio are talking to you

 Steal

 People talk to you that others can’t hear

 You see things others can’t

 Fear of being abandoned

 Hurts others without sadness

You are extremely gifted and talented

Most people are pathetic and need to realize you are superior

 Extreme fear of being judged by others

 Won’t make decisions on own

 Can’t throw anything away

 Frequent problems in all your relationships

People always hurt you

You can read others’ thoughts

You always feel empty inside

You have very high standards on how things should be done.

You have a hard time completing tasks

**Authorization for Release of Protected Health Information**

**(Also known as PHI)**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Mailing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Pride Mental Health to use and/or disclose and receive confidential information from my health records, which may include information about (but not limited to) medication management, physical health, psychiatric diagnosis, and/or treatment to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_ Coordination of Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are currently requesting a copy of the following records:

 all for last 6 months;

 all for last 12 months; or

 specific: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Signature Date

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Guardian/Authorized Person Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Authorized Person Signature Date

**Authorization for Release of Protected Health Information**

**(Also known as PHI)**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Mailing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_ Coordination of Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Guardian/Authorized Person Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Authorized Person Signature Date

**Authorization for Release of Protected Health Information**

**(Also known as PHI)**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Mailing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_ Coordination of Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Signature Date

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Guardian/Authorized Person Name (Print)

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Address (Mailing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Guardian/Authorized Person Name (Print)

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Guardian/Authorized Person Name (Print)

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