Outpatient Counseling Intake Packet

All information submitted is confidential, encrypted, and meets HIPAA requirements for privacy and confidentiality

Date *

Month Day Year

The location I am seeking services at: *

- ☐ St.Cloud
- ☐ Kissimmee
- ☐ Please contact me to help select the best site for me

Name *

First Name Last Name

Birthdate *

Month Day Year

Information on this form provided by: *

- ☐ Self
- ☐ Parent/Guardian
- ☐ Other

Relationship to client *

I was referred by: *

Health Screening

Recent immunizations (please list if applicable)

Allergies (please list if applicable)

Do you have any of the following (please check all that apply; if NONE, please sct the final checkbox): *

- ☐ Fractures/Dislocations
- ☐ Arthritis/Back/Neck Problems
- ☐ Weight Gain/Loss in the past 6 months
- ☐ Heart Problems/Chest Pains
- ☐ Heart Murmur
- ☐ Thyroid Problems
- ☐ Gastrointestinal Problems
- ☐ High/Low Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Kidney/Urinary Problems
- ☐ Stroke/Seizure/Severe Headache
- ☐ Chronic Bronchitis/Emphysema
- ☐ Diabetes
- ☐ Ringing in the Ears
- ☐ Sexually Transmitted Infections
- ☐ Ankle/Leg Swelling
- ☐ Asthma/Difficulty Breathing
- ☐ Chronic Bronchitis/Emphysema
- ☐ Lung Problems
- ☐ Swallowing Problems
- ☐ Nausea/Vomiting
- ☐ Unsteady Walks or Falls
- ☐ Dizziness/Blackouts/Fainting
- ☐ Ulcer/Rectal Bleeding
- ☐ Mental Illness
- ☐ Hepatitis/JaundiceMononucleosis
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Cold/Sore
- ☐ Throat/Sinusitis
- ☐ Bleeding Disorders/Anemia
- ☐ HIV/AIDS
- ☐ Other (please explain below)
- ☐ None of the above, I have no current medical issues

Name of primary care provider *

Date of last physical exam

Month Day Year

May we contact your healthcare provider to request further information about your medical condition, if applicable? *

- ☐ Yes
- ☐ No
- ☐ n/a

Do you need a referral for a primary care provider? *

- ☐ Yes
- ☐ No

If you have not seen a Primary Care Physician in the last 12 months we strongly suggest you make an appointment, if you do not have a PCP
your Primary Counselor will assist you with a local PCP referral.
I am aware that maintaining my health is important, especially when taking medications. As such I am aware of the necessity to schedule yearly physical and eye exams. It is also important to get routine lab work (CBC, Chemistry Prole, and Urinalysis); EEG (electrocardiogram), and Thyroid Profile whenever it is recommended. If I am on medication I will be asked to get lab tests done to test my medication level, for example, Lithium Level. I understand it is my responsibility to follow through with the above recommendations.

Thank you for choosing The Transition House Inc. to provide you with services, please read over the following documents carefully and if you have any questions please inform staff and we will clarify or answer any questions that you may have.

What is the reason you are seeking services today (please check all that apply)? *

- ☐ Mental Health Evaluation
- ☐ Substance Use Evaluation
- ☐ Psychiatric Evaluation
- ☐ Individual Counseling
- ☐ Couples Counseling
- ☐ Family Counseling
- ☐ Group Counseling
- ☐ Psychoeducational Classes
- ☐ Psychological Evaluation
- ☐ Case Management
- ☐ BIP Evaluation

Receipt of Privacy Practices

The Transition House has the right to change the way information is shared and to make changes for all protected health information it keeps. Changed forms will be given to you and displayed where you can see them.
I have received a copy and understand my rights as it applies to the Private Health Information that The Transition House keeps about the services given to me.
CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS
The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not disclose to a person outside this facility that a client is attending the program or disclose any information identifying a client as a drug abuser, unless one of the following apply:
1. The client consents in writing.
2. The disclosure is permitted by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
Violations of Federal law and regulations are a crime and suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.
Federal law and regulations do not protect any information relating to a crime committed either at the facility or against any person who works for the facility or about any threat to commit such a
Federal law and regulations do not protect any information relating to suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities.
Reference 42 U.S.C.290dd.3 and 42 U.S.C.290ee.3 FOR Federal law 42 CFR Part 2 for Federal

Date *

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Consent for Treatment

Before we begin working with you we are required to have your consent for interview. Please read the following statement. I certify that I am participating in an interview with the Outpatient program for services. I give my consent for the initial interview to begin.
I voluntarily agree to participate in The Transition House Treatment Outpatient Program. I understand that my sincere and successful participation in this program will enhance by well-being, as well as promote stability at home, school, and in the community.
Participation in this program is not a guarantee against prosecution or ultimate incarceration. I hereby agree to participate in the Program. The conditions of the program and my responsibilities have been reviewed and explained to me by a Transition House Representative. I have been informed of the services provided by the agency and of my rights pertaining to confidentiality. I understand that this document serves as a formal agreement to accept and participate in services.

Date *

Month Day Year

Consent for Inter-Agency Communication

CONSENT FOR INTER-AGENCY COMMUNICATION
I authorize The Transition House's Inspire Counseling and Support Center to receive or communicate pertinent information related to the client and services being provided during participation in the program. This may include, but is not limited to the exchange of written, including via secure encrypted e-mail, or verbal information with contracted agencies. I understand that this information will be protected and that confidentiality will be safeguarded.

Date *

Month Day Year

The Transition House and Inspire Counseling and Support Center have the right to change the way information is shared and to make changes for all protected health information it keeps. Changed forms will be given to you and displayed where you can see them

Confidentiality Agreement

The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not disclose to a person outside this facility that a client is attending the program or disclose any information identifying a client as a drug abuser, unless one of the following apply:
1. The client consents in writing.
2. The disclosure is permitted by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Violations of Federal law and regulations are a crime and suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal law and regulations do not protect any information relating to a crime committed either at the facility or against any person who works for the facility or about any threat to commit such a crime. Federal law and regulations do not protect any information relating to suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities. Reference 42 U.S.C.290dd.3 and 42 U.S.C.290ee.3 FOR Federal law 42 CFR Part 2 for Federal regulations

Date *

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Grievance Procedure

Anytime you think that an action taken by a Transition House Representative is unjust or you believe that you are being treated unfairly, or you are dissatisfied with the services, you can make a complaint. This complaint is called a GRIEVANCE. To file a grievance, the procedure is as follows:
First, if possible, try to work out the issue with The Transition House Representative and/or their Supervisor. If this is not successful, write out your grievance on a Grievance Form posted by the Grievance Procedure and give to either the Supervisor of your program or a Transition House Representative with whom you feel comfortable. Within fifteen (15) working days, the Supervisor will discuss the grievance with you and try to resolve the matter. The Supervisor will write you as to what, if any action will be taken on your grievance. If you are not satisfied with the Supervisor's decision, you have the right to appeal, in writing, to the Chief Executive Officer or you have the right to request a formal hearing with The Transition House, Inc., the Chief Operating Office, and the CEO. The administration of The Transition House has fifteen (15) working days to review, investigate your grievance, and notify you of their findings and any actions that may be warranted. A final formal hearing would be scheduled at your convenience and a resolution to your satisfaction will be sought as quickly as possible.
All grievances will be reviewed by the Quality Management Committee.
NOTE: NO ACTION WILL BE TAKEN AGAINST YOU FOR FILING A GRIEVANCE
Please note the following phone numbers if you would like to get further assistance.
Disability Rights Florida: 1-800-342-0823
Florida Abuse Hotline: 1-800-96-abuse (22873)
DCF Substance Abuse & Mental health Circuit Program Office: 1-850-778-4079

Date *

Month Day Year

Client Rights

The following are your rights as a client who has elected to receive services from The Transition House Inc. agency:
1. To receive services without regard to race, sex, age, creed, or religion.
2. Your personal dignity is recognized and respected in providing care and treatment.
3. To receive services within the least restrictive environment possible.
4. To not be denied services based solely on race, gender, ethnicity, age, sexual orientation, HIV status, prior service departures, disability, language, socioeconomic status, religion, or relapse.
5. I understand that I have the right to request a copy of my file by notifying The Transition House program in writing and providing proper identification.
6. To receive treatment from an adequate number of competent, qualified and experienced professional Clinical staff to supervise and implement the treatment plan.
7. You have the right to request the opinion of a consultant at your expense or to request a review of your treatment plan, as provided in specific procedures of The Transition House.
8. You may request a referral through the Clinical Director.
9. You have the right to know the risks, side effects, and benefits of all medication and treatment procedures used and informed available alternate treatment procedures.
10. You have the right, to the extent permitted by law, to refuse the specific medications or treatment procedures.
11. You have the right to know as appropriate, the cost of services rendered, the source of our reimbursement, and any limitations placed on duration of services.
12. You shall be informed of any proposed change in the professional staff responsible for you or for any transfer of you within or outside the organization.
13. You have the right to initiate a complaint or grievance procedure through the Clinical
14. Your records are protected under state and federal confidentiality laws, whichunauthorized disclosures of information and to have an understanding of these laws.
15. To be assured freedom from neglect, abuse, exploitation or any form of corporal punishment and should you feel that you are being mistreated, contact Florida Abuse Hotline #: 1-800-96-ABUSE (22873) or DCF Substance Abuse & Mental Health Circuit Program
16. To be assured that any search and seizure is carried out in a manner consistent with program standards and only to ensure the safety, well-being, and security of all clients and staff.

In addition to the above, all service recipients are granted the following:
1. Right to individual dignity - The individual dignity of the client must be respected at all times and upon all occasions, including any occasion when the client is admitted, retained or transported. Substance abuse clients who are not accused of a crime or delinquent act may not be detained or incarcerated in jails, detention centers, or training schools of the state, except for purposes of protective custody in strict accordance with the policy. A client may not deprived of any constitutional rights.
2. Right to non-discriminatory services - TTHI may not deny a client access to counseling services solely on the basis of race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, prior service departures against medical advice, disability or number or relapse episodes. TTHI may not deny a client who takes medications, prescribed by a physician, access to services solely on that basis. TTHI, who receives state funding to provide substance abuse services, may not deny client access to services based solely on the inability to pay for said services. Each client in treatment must be afforded the opportunity to participate in the formulation and periodic review of his/her individualized treatment plan to the extent of his/her ability to participate. It is the policy of the state to use the least restrictive and most appropriate services available, based on the needs and the best interests of the client and consistent with optimum care of
3. Right to quality services - Each client must be delivered services suited to his/her needs, administered skillfully, safely, humanely, with full respect for his/her dignity and personal integrity and in accordance with all statutory and regulatory requirements. These services must include the use of methods and techniques to control aggressive client behavior that poses an immediate threat to the client or to other persons. Such methods and techniques include the use of restraints (TTHI does not use restraints), the use of seclusion, the use of time-out, and other behavior management techniques.
4.Right to communication - Each client has the right to communicate freely and privately with other persons within the limitations imposed by TTHI because the delivery of services can only be effective in a substance abuse free environment, close supervision of each client's communication and correspondence is necessary, particularly in the initial stages of treatment. TTHI maintains rules for telephone, mail, and visitation rights, giving primary consideration to the wellbeing and safety of clients, staff and the community. It is the duty of TTHI to inform the client and his/her family, if applicable, at the time of admission about TTHI rules relating to communications and correspondence. This is included in the Client Orientation process.

5.Rights to care and custody of personal effect of clients - A client has the right to possess clothing and other personal effects. TTHI takes temporary custody of the client's personal effects only when required for medical and safety reasons, with the reason for taking custody and a list of the personal effects recorded in the client's clinical record.
6. Right to confidentiality of client records - The client records of TTHI services and documentation will be maintained in the strictest confidence and in accordance with CFR 42, part 2 as well as, 45 CFR 164.520 and 45 CFR 165. Such records may not be released or disclosed without the written consent of the client. TTHI is permitted or required by the Privacy regulations to use or disclose protected health information without the individual's written authorization including:
-Uses and disclosures required by law Uses and disclosures for public health activities -Disclosures about victims of abuse, neglect or domestic violence
-Uses and disclosures for health oversight activities Disclosures for judicial and administrative proceedings
-Disclosures for law enforcement purposes
-Uses and disclosures about decedents
-Uses and disclosures for research purposes
-Uses and disclosures to avert a serious threat to health or safety
-Uses and disclosures for specialized government functions
-Disclosures for workers compensation
TTHI may disclose information through a court order that shows good cause for the disclosure, the court shall examine whether the public interest and the need for disclosure outweigh the potential injury to the client, or to the service provider client relationship or to the service provider as well.
7. Right to counsel - Each client is informed that he/she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization or treatment and that he/she may apply immediately to the court to have an attorney appointed if he/she cannot
8.Right to Habeas Corpus - At any time, and without notice, a client involuntarily retained by a provider, or the client's parent, guardian, custodian or attorney on behalf of the client, may petition for a Writ of Habeas Corpus to question the cause and legality of such retention and request the court issue a writ for the client's release.
9. Liability and immunity - Any transition house representative who violates or abuses any right or privilege of a client under this policy are liable for damages as determined by law. All persons acting in good faith, reasonably and without negligence in connection with the preparation or execution of petitions, applications, certificates or other documents or the apprehension, detention, discharge, examination, transportation or treatment of a person under the provision of this chapter shall be free from all liability, civil or criminal, by reason of such acts.
10. Provisions - TTHI shall make provisions for informing the client, family member or authorized guardian of their rights and responsibilities, assisting in the exercise of those rights and an accessible grievance system for resolution of conflicts. This will include ensuring the client they can make a grievance for any reason with cause. TTHI will post the grievance procedure and make the forms accessible. This will be explained to the client at Orientation as well as the appeal process and the time frames for resolution. The client will be given a resolution in writing, if appropriate.
The following rights shall be afforded to all clients by all licensees and are not subject to
Clients have the right to be fully informed before or upon admission about their rights and responsibilities and about any limitations on these rights imposed by rules of the facility. The facility must ensure that the client is given information about his or her rights that shall include at least the following: A statement of the specific rights guaranteed the client by these rules and applicable state and federal laws; A description of the facility's complaint and grievance procedures; A listing of all available advocacy services; A copy of all general facility rules and regulations for clients; and, The information must be presented in a manner or format that promotes understanding by clients of their rights and an opportunity must be given to clients to ask questions about the information. If a client who is unable to understand this information at the time of admission later becomes able to do so, the information must be presented to the client at that time. If a client is likely to continue indefinitely to be unable to understand this information, the facility must promptly attempt to provide the required
information to a parent, guardian, or other appropriate person or agency responsible for protecting the rights of the client;
Clients have the right to voice grievances to staff of the facility, to the licensee, and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination or reprisal; Clients have the right to be treated with consideration, respect and full recognition of their dignity and individuality; Clients have the right to be protected by the licensee from neglect; from physical, verbal and emotional abuse (including corporal punishment); and from all forms of misappropriation and/or exploitation; Clients have the right to be assisted by the facility in the exercise of their civil rights;
Clients have the right to be free of any requirement by the facility that they perform services which are

ordinarily performed by facility staff; If residential services are provided, clients must be allowed to send personal mail unopened and to receive mail and packages which may be opened in the presence of staff when there is reason to believe that the contents thereof may be harmful to the client or others; Clients have the right to privacy while receiving services; Clients have the right to have their personal information kept confidential in accordance with state and federal confidentiality laws; Clients have the right to ask the facility to correct information in their records. If the facility refuses, the client may include a written statement in the records of the reasons they disagree; Clients have the right to be informed about their care in a language they understand; and, Clients have the right to vote, make contracts, buy or sell real estate or personal property, or sign documents, unless the law or a court removes these rights.
The following rights must be afforded to all clients by all licensed facilities unless
modified in accordance with rules 0940-05-06-.07 or 0940-05-06-.08:
Clients have the right to participate in the development of the client's individual program or treatment plans and to receive sufficient information about proposed and alternative interventions and program goals to enable them to participate effectively; Clients have the right to participate fully, or to refuse to participate in community activities including cultural, educational, religious, community services, vocational and recreational activities; If residential services are provided, clients must be allowed to have free use of common areas in the facility with due regard for privacy, personal possessions, and the rights of others:
Clients have the right to be accorded privacy and freedom for the use of bathrooms when needed; Clients shall be permitted to retain and use personal clothing and appropriate possessions including books, pictures, games, toys, radios, arts and crafts materials, religious articles, toiletries, jewelry and letters;
If residential services are provided and if married clients reside in the facility, privacy for visits by spouses must be ensured, and if both spouses are clients residing in the facility, they must be permitted to share a room; If residential services are provided, clients have the right to associate and communicate privately with persons of their choice including receiving visitors at
If residential services are provided, persons supported have the right to be given privacy and freedom in the use of their bedroom/sleeping area.

ABUSE REPORTING POLICY
Florida Statute 425 requires that any child abuse allegations revealed to any Transition House employee will require that a telephone and/or written report be submitted to the State of Florida Department of Children and Families Abuse Registry. The caller is not responsible for determining the validity of the abuse. I understand that The Transition House Representative will not discourage or prevent me from contacting the Florida Abuse Hotline #: 1-800-96-ABUSE (22873) or DCF Substance Abuse & Mental Health Circuit Program Office #: 1-850-778-4079

By signing below, I agree that I have read the client rights and abuse reporting policy

Date *

Month Day Year

INSPIRE COUNSELING & SUPPORT CENTER OUTPATIENT ORIENTATION

Welcome to Inspire Counseling & Support Center! Our vision is to provide counseling services to the behavioral health population in a safe and therapeutic environment, which includes individualized treatment planning, behavioral health treatment, addiction education as applicable, and exploration of client strengths to regain a healthy and productive lifestyle.

Our program treatment philosophy stems directly from our mission and values. Our mission is to Inspire Brighter and Healthier Lives, which is our overall service aim. Our agency has five main values that we strive to demonstrate in all our services we provide. Our agency values include, 1) Be Compassionate, 2) Empower Others, 3) Embrace Diversity, 4) Foster Innovation, and 5) Promote Collaboration. These values are the "how" of our service goal. With these foundations, our treatment philosophy is to provide mental health and substance use services that are evidence-based, collaborative and uniquely individualized to each client, culturally and linguistically considerate and competent, bio-psychosocially comprehensive, and at each client's own current stage and readiness for change. Our treatment philosophy holds that positive change is possible and is the expected outcome of our work.

Following your initial evaluation and throughout treatment we may make recommendations for other services to support stability of mind, body, and soul. We also will provide individualized and group counseling services to enhance this process when deemed necessary. Please review and complete the following information to get a better understanding of our program services and participation expectations. Let us know if you have any questions!

OFFICE HOURS
Our St. Cloud office is open Monday thru Friday from 8:00a-6:00p. Our Kissimmee office is open Monday, Thursday, and Friday 8:00a-6:00p and Tuesday and Wednesday 8:00a-7:00p. We are closed on all major holidays. We do not provide on call staff for any crisis management services. Even during office hours, in the case of an emergency call 911 immediately. Your therapist can be contacted following the emergency.

During normal business hours the site director or qualified designee will have access to an agency-licensed prescribing medical professional (i.e., physician, nurse practitioner, physician's assistant).

AFTER HOURS EMERGENCIES
In the instance of any after-hours emergency, 911 should be contacted immediately. Any non-emergency questions after business hours regarding medications or other questions that need immediate attention that cannot wait until the next business day, please contact 407-530-7304.

Additional 24-hour resources to utilize are listed below:

24-hour Gambling Helpline (chat and talk available): 800-994-8448
24-hour Mental Health and Addiction Resource Helpline (chat and talk available): 800-662-4357
Florida 211: 988
National Suicide Prevention Lifeline: 800-273-TALK (800-273-8255)
Veterans Crisis Line: 800-273-8255 (option 1)

PROGRAM RULES & REGULATIONS
The following rules and regulations have been established by the program to ensure that a safe and therapeutic environment is maintained for the benefit of everyone. The examples listed below are not meant to be all-inclusive but are a representation of the intent.

Acts of physical violence or threats of violence toward staff or clients will not be tolerated.
Physical violence will result in police intervention.
No abusive, vulgar, or profane language will be permitted while on the premises.
No overt sexual conduct will be permitted Possession and/or use of any type of weapon on clinic premises will be cause for immediate termination and police intervention as deemed necessary.
No photos are to be taken in the facility, no audio or video recordings should be conducted within the building of any clients or staff
Use, possession of and/or dealing of any illicit drugs or substance is prohibited on clinic premises and could result in immediate termination from treatment and police intervention.
Theft of any kind within the program will result in immediate termination and police intervention as deemed necessary.
You must inform the counselor of any prescription drug you may be taking to avoid drug interaction/contraindications.

Loitering or panhandling is not permitted on premises.
For individuals in our PHP program, MAT program, or any court ordered services, you must provide a urine sample upon request from counselor and will be charged for all urine screenings as listed in the payment policy, if not covered by your insurance.

Payment Policy

The Transition Outpatient Center operates on Health insurance benefits and patient fees for services. Fees are due at the time services are rendered and must be paid in money order, check, or credit card. **NO CASH WILL BE ACCEPTED.**
We as an agency will abide by all bylaws of the No Surprise Act (NSA).
A $45.00 fee applies to all returned checks. No refunds will be provided for services already
If any scheduled appointments are missed or canceled without at minimum 24-hour notice, the client is responsible for a $25 cancellation fee.
Additional Fees: (subject to change)
Substance Abuse Evaluation: $125.00
Mental Health Evaluation: $125.00
Child Eval:$125.00
Individual Counseling: $50.00
Telehealth Counseling: $40.00
Group Counseling: $20.00
Couples Counseling $120.00
Family Counseling $75.00
Psychiatric Evaluation $175.00
Medication Management $75.00
Psychological Evaluation (depending on type) $210.00 - $3550.00
Court representation: $150 per hour
Court Probation Reports: $35.00
Urine Drug Screen:*CLIA approved rapid results drug screen on site $15.00
A refund will be issued if it is an insurance requesting an overpayment refund. Before the request is filed a dispute/appeal must be processed to determine if a refund is genuinely necessary.
A refund will be issued in the case where an individual is a self paying client and has prepaid for services. If the individual cancels within the appropriate time frame that amount will be refunded to
I am acknowledging that I understand the program rules and payment policies, I am acknowledging that I have received a copy of each of these from an employee at TTHI.

Date *

Month Day Year

COMMUNICABLE DISEASES
I understand that The Transition House, Inc. is obligated by law to report any instance of communicable diseases to the Florida Department of Children and Family Services.

AFTER HOURS EMERGENCIES
If you are having an emergency please call 911. Any non-emergency questions after business hours regarding medications or other questions that need immediate attention that cannot wait until the next business day, please contact 407-530-7304.
During normal business hours the site director or qualified designee will have access to an agency licensed prescribing medical professional (i.e., physician, nurse practitioner, physician's assistant).

GUARANTEE OF PAYMENT

I, The undersigned, hereby agree to guarantee the payment of the bills for services rendered by The Transition House, Inc. Also, I agree to sign as guarantor or as client that in consideration of the services to be rendered to me, to be hereby jointly and individually obligated to pay the account of TTHI. in accordance with the regular rates and terms of TTHI. I understand that if the account is referred for collection by an attorney or collection agency, I will be responsible to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any account(s) not paid when due.

In consideration of the treatment and services rendered or to be rendered, by The Transition House, Inc. to the extent permitted by law, I hereby irrevocably assign, transfer and set over to TTHI (II) all of my rights, title and interests to medical reimbursement, including but not limited to, (III) the right to designate a beneficiary, add a dependent, eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreements otherwise payable to me for whose services rendered by TTHI during the dependency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery of said policy (s) of insurance, but shall not be construed to be an obligation of TTHI to pursue any such right of recovery. I hereby authorize the insurance company's) or third party payers) to pay directly to TTHI all benefits due for services rendered.

Date *

Month Day Year

Consent for Release of Information

I, the undersigned authorize TTHI to release all client information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which I am being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Transition House, Inc. to any insurance company, and/or third party payers, or representatives providing coverage for this admission, or to any TTHI representative. I acknowledge that this information may not be released to any other person or entity unless I authorized the TTHI Representative to do so.

I, the undersigned acknowledge that such disclosure shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released. Furthermore, I authorize TTHI to release information for the purpose of obtaining preauthorization for treatment and concurrent review and to release that information to medical review agencies, and/or third party payers, providing coverage or having responsibilities for the admission.

I, the undersigned have been informed by the TTHI Representative the confidentiality of alcohol and drug abuse client records are protected by federal law regulations. Therefore, I understand that TTHI may not disclose information to anyone outside of TTHI, which would identify any clients as an alcohol or drug abuser unless the client has consented in writing; the disclosure is allowed by a court order, or the disclosure is made to medical or other qualified personnel in accordance with Federal regulations.

I, the undersigned have been informed by the TTHI Representative that the Federal law and regulations do not protect information regarding a crime or a threat to commit a crime or any information regarding suspected child abuse or neglect from being reported to appropriate State or

I, the undersigned hereby authorize free exchange of medical record information, including but not limited to the release of client information indicated above, between TTHI and the attending therapist, his/her group practice association and/or other health care agencies, facilities and/or professionals which may provide services to clients during this admission. This includes the authorization to discuss the client's specific information indicated above with a TTHI Representative.

I, the undersigned acknowledge his/her right to request and receive a copy of this authorization for release of information and may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. Furthermore, the undersigned acknowledges that this authorization shall be valid until all third party payers liable are evolved for this admission of service.

Date *

Month Day Year

ADVANCE DIRECTIVE ACKNOWLEDGEMENT
The undersigned acknowledges the following: I have been given written materials about my right to accept or refuse treatment: I have been informed of my rights to formulate Advance Directives. I understand that I am not required to have an Advance Directive in order to receive treatment at this facility I understand that the terms of any Advanced Directives that I have executed will be followed by the facility and the employees of TTHI to the full extent of the law. PLEASE CHECK ALL THAT APPLY:

*

- ☐ Yes, I have a medical advance directive
- ☐ No, I do not have a medical advance directive
- ☐ Yes, I have a psychiatric advanced directive
- ☐ No, I do not have a psychiatric advance directive

Date *

Month Day Year

Consent for Telehealth Services

Please review each statement and sign below indicating that you have read and understood.I have been informed of, and agree to, the following regarding telehealth services:
1. Telehealth services are similar to the services offered in offices but are instead conducted via HIPAA-compliant encrypted live video.
2. I understand that telehealth services are provided as a means of ensuring access to care and that I am not required to participate in them. I may withdraw consent to participate in such services at any time without penalty. If in-person services are not being offered, referrals will be provided to me.
3. I understand my provider will be in a private, closed-door setting during my appointment and that no additional individuals will be in the room with my provider unless my provider notifies me and obtains my permission for the additional person to be present during my appointment.
4. I agree not to have any other individuals present at my location during the live-video appointment unless I inform my provider first.
5. I agree to participate in services in a location that maintains my privacy and safety. Services cannot take place in my car, in public, or in any other unsafe setting.
6. I understand live-video services may have delays, signal interruptions, and outages that may impact the overall quality of the service and may at times prevent services from occurring. I understand that if service is delayed, interrupted, or experiences an outage, my provider will notify me at my phone number on file.
7. I agree that the web-link for the live-video service may be emailed, texted, and/or verbally provided to me.
8. I understand that telehealth services are provided at equivalent rates as in-office services and my insurance company, or myself if self-pay, will be billed for the services provided.
9. I understand that I will need to use my own device (cell phone, laptop, tablet, desktop) and my own internet connection to participate in telehealth services.
10. I agree to provide emergency contact information below, that provider may use if there is an emergency during the telehealth session. I also agree to immediately call 911 if there is an emergency occurring with me and/or at my location.

Date *

Month Day Year

Middle Name

Preferred Name

Age *

Social Security Number *

I confirms that the social security number provided is accurate. Any misuse, unauthorized access, or sharing of this information is strictly prohibited *

- ○ I Confirm

Sex *

- ○ Male
- ○ Female

Gender identity (if applicable)

Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Primary Phone Number *

Please enter a valid phone number.

Cell Phone Number

Please enter a valid phone number.

Email

example@example.com

If an incident or emergency arises, I provide my consent to release the following to an emergency contact: My known whereabouts *

- ○ Yes, the above may be provided to my emergency contact
- ○ I decline consent to provide the above to my emergency contact

If an incident or emergency arises, I provide my consent to release the following to an emergency

contact: Details of the incident or emergency *

- ○ Yes, the above may be provided to my emergency contact
- ○ I decline consent to provide the above to my emergency contact

If an incident or emergency arises, I provide my consent to release the following to an emergency contact: Disclosure of any current substance use related to the incident or emergency *

- ○ Yes, the above may be provided to my emergency contact
- ○ I decline consent to provide the above to my emergency contact

Date *

Month Day Year

For us to get to know you a bit more, please complete the following information to ensure we can provide you with the best treatment possible which may include additional referrals to other community agencies.

LIVING ARRANGEMENT/HOUSING STATUS *

- ☐ Independent Living – Alone
- ☐ Independent Living with Relatives
- ☐ Dependent Living with Relatives
- ☐ Dependent Living with Non-Relatives
- ☐ Staying With Friends/Family – Temporarily
- ☐ Shelter/Crisis Residence
- ☐ Foster Care Home
- ☐ Supported Housing
- ☐ Assisted Living Facility
- ☐ Correctional Halfway House

CULTURE/RACE/ETHNICITY

Primary Language *

Race: *

Please Select

Ethnicity: *

Please Select

Interpeter needed *

- ○ Yes
- ○ No

Family

Marital Status *

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Military Veteran Status

Are you a veteran? *

- ○ Yes
- ○ No

Legal Information

Are you on probation *

- ○ Yes
- ○ No

Education History

Highest Education Level Completed *

Employment & Monthly Income

Are you employed? *

- ◯ Yes
- ◯ No

Type and Amount of Monthly Income

Employed Full Time:

$ Monthly Amount Earned Above. Leave Blank if N/A

Employed Part Time:

$ Monthly Amount Earned Above. Leave Blank if N/A

Alimony:

$ Monthly Amount Earned Above. Leave Blank if N/A

Child Support:

$ Monthly Amount Earned Above. Leave Blank if N/A

Disability:

Pension:

$ Monthly Amount Earned Above. Leave Blank if N/A

SSI/SSDI:

$ Monthly Amount Earned Above. Leave Blank if N/A

VA non-service connected:

$ Monthly Amount Earned Above. Leave Blank if N/A

Other:

$ Monthly Amount Earned Above. Leave Blank if N/A

Client Attendance Policy

Inconsistent attendance and no-shows are detrimental to the successful progress of treatment, and thus it is the policy of Inspire Counseling and Support Center to minimize and mitigate clinically unfeasible late arrivals, less than 24-hour cancellations, and no- shows.

GENERAL

All clients will be informed of and will attest via signature their receipt of Inspire Counseling and Support Center's attendance policy.
At the outset of treatment, the admitting clinician will verbally review the attendance policy with all clients and/or their guardians.
A signed copy of the intake packet, inclusive of the attendance policy will be attached to each client's electronic health record file.
All new evaluations, including additional evaluations for existing clients (such as psychiatric evaluations), will receive a one-week advance telephonic reminder call, as well as a reminder call the day prior, reiterating the appointment date and time.
All scheduled individual psychotherapy or other similar individual services will receive a telephonic reminder call the day prior, reiterating the appointment date and time.
Text messaging service may be used to supplement telephonic reminder calls; however, reminder calls will occur at the timeframes noted above regardless of the use of text messaging reminders.

ATTENDANCE PROCEDURES

Clients who cancel scheduled appointments with less than 24 hours' notice or who do not show for

scheduled appointments will be assessed a no-show fee of $25.00. This does not apply to appointments that serve to start services since such clients have not yet been informed of the attendance policy (i.e., mental health or substance abuse evaluations or any other initial evaluation type where no services have occurred prior).
Clients will be given a 15-minute grace period to arrive for their appointment. Arrival after 15 minutes will be considered a no-show.
The scheduled appointment will not take place for clients arriving more than 15 minutes late, and a no-show fee will be assessed. The assigned clinician will meet with any client arriving after 15 minutes whenever feasible to provide clinical rationale for why the appointment cannot take place.
Clinical staff, whenever possible the assigned clinician, will contact the absent client to inform of the missed appointment and offer to reschedule the appointment to a later date and time to promote continuation of care. This client contact will occur the same day when possible but no later than the next business day (no-show fees as outlined above still apply regardless of clinical contact and reschedule outcomes). Contact must be documented in the Clinical record.
Clients are permitted three missed appointments due to less than 24-hours' notice or no-show during their treatment. Clinical services will be terminated upon a fourth missed appointment. Clients will also receive a termination letter if there has been no verbal contact with the client for 90 days.

PROCEDURE FOR MISSED APPOINTMENTS

1. The company attendance policy will be reviewed in the next session by the assigned clinician with every client who has missed an appointment due to less than 24-hours' notice or no-show.
2. A client who has had services terminated due to attendance policy violation is eligible for service reinstatement based on the following:
    a. First Attendance Policy Case Closure - immediate reinstatement with an updated signature on the attendance policy section of the intake packet and a comprehensive review of the attendance policy with the client in the first return session by the assigned clinician.
    b. Second Attendance Policy Case Closure - eligible for reinstatement after 30 days, with an updated signature on the attendance policy section of the intake packet and a comprehensive review of the attendance policy with the client in the first return session by the assigned clinician.
    c. Third Attendance Policy Case Closure - eligible for reinstatement after 60 days, with an updated signature on the attendance policy section of the intake packet and a comprehensive review of the attendance policy with the client in the first return session by the assigned clinician.
    d. Fourth or More Attendance Policy Case Closure - eligible for reinstatement only upon approval of a member of the agency leadership team (i.e., CEO and other Chiefs, Director of Clinical Services).
3. Should a contracting entity outline differences in missed appointment fees, the contracting entity fee will supersede the agency's $25.00 assigned fee.
4. Should a contracting entity outline differences in the timeframes or other stipulations regarding readmission following attendance policy case closure, the contract entity fee will supersede this policy.

Client's or Guardian's Signature:

Date *

Month Day Year

Email, Voicemail, and Text Message Consent

1) I understand that emails received by Inspire staff may
not be read immediately and may take several business days to be reviewed.
2) I understand that email cannot be used for emergencies or
to convey emergency information of any kind, including requesting emergency
services.

3) Inspire uses encrypted email; however, I understand that
sending emails to Inspire may not be encrypted and my basic information and the content of my email may be accessible to unintended sources if I send via unencrypted methods.
4) I understand that Inspire does not provide therapy services via email and that concerns, issues, or experiences shared via email
will only be addressed via scheduled therapy sessions.
5) I understand that a copy of any email I send will be saved to my electronic medical record.
6) I understand that emails I send may not be responded to or may receive a response that differs from email, such as a phone call or addressing the email content during scheduled therapy sessions.
7) I understand that email is not a guaranteed method of communication; emails may not reach the intended recipient for many reasons. I understand that Inspire is not responsible for errors resulting from emails I send, including if I send an email to an unintended person or an email is not received. I am responsible for securing my email, including preventing others from viewing what I send or receive and ensuring I send email to the intended recipient.

Date *

Month Day Year

I consent to Inspire leaving me voicemails on my provided phone number/s. *

- ○ Yes
- ○ No

I consent to Inspire Counseling & Support Center sending me text messages related to my services, including questions and assessment measures, to my provided cellular phone number/s *

- ○ Yes
- ○ No

Medication Services

Consent to evaluate/treat: I voluntarily consent that I will participate in mental health (e.g., psychological, or psychiatric) evaluation and/or treatment by staff from Onrise Care. I understand this treatment may include tele health as is allowed under state and federal law. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

The benefits of the proposed treatment, Alternative treatment modes and services, the manner in which treatment will be administered, expected side effects from the treatment and/or the risks of side effects from medication (when applicable), probable consequences of not receiving treatment.

Benefits to evaluation/treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professions, to understand the nature and cause of and difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of the evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health

status, quality of life, and awareness of strength and limitations.

Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges, including co-payments and deductibles. Fees are available to me upon request.

Confidentiality, harm, and inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at Onrise Care, and I consent to disclosure for use by Onrise Care's staff for the purpose of continuity of my care. Per Tennessee mental health law, information provided will be kept confidential with the following exceptions:

If I am deemed to present danger to myself or others, if concerns about possible abuse or neglect arise, or a court order is issued to obtain records.

Right to withdraw consent: I have the right to withdraw my consent for evaluation/or treatment at any time be providing a written request to the treating clinician.

Expiration of consent: This consent to treat will not expire from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Signature of client or legal guardian for minor under age 16

Date *

Month Day Year

Medication Management Expectations

As a client of Inspire Counseling & Support Center, we are pleased to be able to provide our clients the opportunity to benefit from ongoing medication management via Telehealth and/or face-to-face in our office. As part of ongoing medication management, we at Inspire Counseling & Support Center support ongoing research establishing that a combination of therapy and psychiatric medication management is superior in its efficacy than therapy and/or medication management alone. Active participation in therapy, as a part of your overall treatment and healing plan, can often address some of the social and/or interpersonal challenges that an individual may face, while medication alone is unable to help an individual to process and develop new skills to use to overcome those challenges. At Inspire Counseling & Support Center, for optimal mental health, we wholeheartedly believe in:

Lifestyle changes first (including a healthy diet, exercise, limited substances, and decreasing stress).
Therapy is a way to help people with a broad variety of life challenges eliminate or control troubling symptoms, so a person can function better and increase well-being and healing.
As an additional part of the treatment plan when appropriate: Medication. Psychiatrists and psychiatric nurse practitioners are trained and are qualified to assess both the mental and physical aspects of an individual's mental health and can prescribe appropriate medication to treat the individual.

As a result of the improved outcomes seen in individual receiving not only medication management but also ongoing therapy, it is an expectation of all the clients receiving medication management through one

of the providers at Inspire Counseling & Support Center to:

Any client receiving medication management through Inspire Counseling & Support Center must be participating and actively involved in therapy. A client's participation in therapy does not have to be with a therapist from Inspire Counseling & Support Center; however, the client must agree to sign a release of information form for the therapist whom the client is working with, so that Inspire Counseling & Support Center can communicate with the therapist to verify client's participation.
Any client receiving medication management through Inspire Counseling & Support Center must have at least one therapy session per month with a therapist.
Any client receiving medication management through Inspire Counseling & Support Center will abide by the attendance expectation of Inspire Counseling & Support Center and will acknowledge that if client misses three appointments within a 60-day period, the client can be discharged from the program and no longer be eligible to receive medication management from Inspire Counseling & Support Center for at least six months. If client is discharged due to nonattendance or nonpayment, client will be provided one last 30-day prescription for any medication to which they were prescribed by the medication management provider at Inspire Counseling & Support Center.
Any client that does not abide by the expectations will be discharged from services and will not be able to receive services from Inspire Counseling & Support Center for a period of six months. If discharged from services because of not being able to meet the expectations, a client will be provided one last 30-day prescription for any medication to which they were prescribed by the medication management provider at Inspire Counseling & Support Center.

Date *

Month Day Year