Outpatient Counseling Intake Packet

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

Date *

Month Day Year

Birthdate *

Month Day Year

Information on this form provided by: *

- ☐ Self
- ☐ Parent/Guardian
- ☐ Other

Relationship to client *

I was referred by: *

Thank you for choosing The Transition House, Inc. Inspire Counseling and Support Center 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
- ☐ Group Counseling
- ☐ Family Counseling
- ☐ Couples Counseling
- ☐ Psychological Evaluation (testing)
- ☐ Psychiatric Evaluation (medication)
- ☐ Case Management

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 Agreement

Credit Card Authorization (optional)

Thank you for choosing The Transition House of Indiana Inc. DBA. Inspire Counseling and Support Center to provide you with services. Please read over the following documents carefully. If you have any questions, please inform staff and we will clarify or answer any questions you may have.

Our mental health professionals include licensed counselors and those who are currently completing license requirements. Master's Level Clinicians who are also working towards licensure will be supervised by credentialed and participating practitioner in accordance with state statutes and licensing regulations. All therapeutic documentation is reviewed by the credentialed practitioner upon submission. Master's Level Clinicians will receive at least once monthly supervision to review any therapeutic services being provided by Inspire. The supervising provider can be reached at (317)-683-8114. By signing below, you are agreeing to treatment provided by one of our counselors, which may be a supervised practitioner currently completing licensure requirements.

Name *

First Name Last Name

Middle Name

Preferred Name

Age

Social Security Number

Gender

Address

Street Address

Street Address Line 2

Primary Phone Number

Please enter a valid phone number.

Cell Phone Number

Please enter a valid phone number.

Email Address

example@example.com

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 1/01/2022

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

The terms of this Notice of Privacy Practices (“Notice”) apply to The Transition House, TTHI and Inspire Counseling and Support Center and its affiliates and its employees. The Transition House, TTHI and Inspire Counseling and Support Center will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by The Transition House, TTHI and Inspire Counseling and Support Center.

We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act (“HIPAA”).
A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such

revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation, and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved in Your Care: We may disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services. You have the right to request to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

• Any purpose required by law.
• Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations.
• If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
• To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
• To your employer when we have provided health care to you at the request of your employer.
• To a government oversight agency conducting audits, investigations, civil or criminal proceedings.
• Court or administrative ordered subpoena or discovery request.
• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
• To coroners and/or funeral directors consistent with law.
• If necessary to arrange an organ or tissue donation from you or a transplant for you.
• If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
• To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following:
(1) to carry out certain treatment, payment, or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you),

(2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law,
(3) as required by law,
(4) for health oversight activities authorized by law,
(5) to medical Examiners or coroners as permitted by state law, or
(6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:
• Public health activities.
• Research purposes provided we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes.
• Treatment and payment purposes.
• Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence.
• Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
• Providing you with a copy of your health information or an accounting of disclosures.
• Disclosures required by law.
• Disclosures of your health information for any other purpose permitted by and in accordance with the

Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
• Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be

made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies, you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid The Transition House, TTHI and Inspire Counseling and Support Center in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights
Department of HHS
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Voice Phone (212) 264-3313
FAX (212) 264-3039
TDD (212) 264-2355

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact The Transition House, TTHI and Inspire Counseling and Support Center Privacy Officer, Jennifer Dellasanta by phone at 978-786-9660 ext 910 or at the following address: Jennifer Dellasanta 3800 5th Street St. Cloud FL 34769.

This Notice of Privacy Practices is also available on our The Transition House, TTHI and Inspire Counseling and Support Center web page at
www.inspiresupportcenter.com and www.thetransitionhouse.org

Date *

Month Day Year

Clinical records are stored in a secure, HIPAA compliant electronic medical record (EMR) system, Credible, which meets all Federal and state privacy and security standards. Only TTHI/ Inspire Counseling & Support Center staff members may access agency client records, electronic and paper, except in cases permitted by Federal, State, or certifying body statutes and rules, such as, but not limited to, for approved auditing or performance oversight purposes. In instances in which approved access is required under Federal, State, or certifying body statutes and rules, clinical record access, electronic and paper, will be time-limited only to the specified period necessary to conduct the stated purpose.

Clients may view, review, inspect, and request and be granted copies of their clinical record.
Clients may verbally request to see their records or have copies provided from their records, a written request is not required of the client.

Any time a client's information is released, either to their self or another entity listed on a ROI, a communication note will be documented in the EMR indicating the information released, who the information was provided to, as well as what method of release (phone, verbal, written, emailed). Any email communication that includes PHI will be sent via a secure email.

Required elements of a client's written consent for the release of records include:
a) the specific name or general designation of the program or person permitted to make the disclosure
b) the name or title of the individual or name of the organization to which disclosure is made
c) the name of the client
d) the purpose of the disclosure
e) how much and what kind of information is to be disclosed
f) the signature of the client and, when required for a client who is a minor, the signature of the person authorized to give consent (under 42 CFR Part 2, 2.14), or, when required for a client who is incompetent or deceased, the signature of a person authorized to sign under 42 CFR Part 2, 2.15, in lieu of the client
g) the date on which the consent is signed
h) a statement that the consent is subject to revocation at any time except to the extent that the program or persons which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.
i) the date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than is reasonably necessary to serve the purpose for which it is given.

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, audits, 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 authorities. 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 *

Month Day Year

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 services through Inspire Counseling and Support Center. 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 an Inspire Counseling and Support Center 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

I authorize 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.
Inspire Counseling and Support Center, 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.

Date *

Month Day Year

Email, Voicemail, & Text Message Consent Form

Email is a common communication method for exchanging brief information. However, there are important limitations to email communications with us. Please review the following and sign below to indicate your understanding:
1) I understand that emails received by Inspire Counseling & Support Center 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 Counseling & Support Center 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 Counseling & Support Center 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 Counseling & Support Center leaving me voicemails on my provided phone number/s *

- ○ Yes
- ○ No

Date *

Month Day Year

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

Date *

Month Day Year

Resolution Policy & Procedure

To ensure that the clients served are afforded unimpeded access to report complaints against the program or staff and to provide a procedure for staff to follow.

1. The treatment staff will review the Resolution Procedure process with the client during admission.
2. The resolution procedure will be posted in plain view at areas designated by the Clinical Director.
3. Any client, family member, or legal guardian has a right to present a resolution request concerning the quality of care of TTHI/Inspire services.
4. The resolution request is reviewed by the Leadership Team if applicable.
5. Clients are advised that filing a resolution request will not result in retaliation or barriers to services.
6. The client presenting a resolution request will complete the Resolution Request form and return it to the resolution request box or employee of TTHI/Inspire and the Director will monitor and review submitted resolution requests within 30 days of alleged occurrence.
7. Clients who experience language barriers will be assisted in completion of the form by an appropriate staff person. Both the client and treatment staff will sign and date the form. The treatment staff signs the line designated as TTHI/Inspire representative.
8. The treatment staff is encouraged to obtain the parent/guardian signature if applicable, but is not required for this particular form.
9. The treatment staff will offer the client a copy of the Resolution Request Form and the original will be retained by the Director of Quality Services.
10. Upon a resolution request form being submitted, the Clinical Director or Chief Clinical Officer (CCO), will initiate investigation of the resolution request and acknowledge receipt of the request to the individual within two (2) business days.
11. The Clinical Director or CCO will complete a thorough investigation of the resolution request, including interviews with the staff and clients, when necessary. The Clinical Director or CCO will attempt to resolve the issue to the satisfaction of the client. The Clinical Director or CCO has 15 business days to attempt to resolve the request and will document all actions taken on the Resolution Request Form.

12. The Clinical Director will communicate the findings of the resolution request form with the client/family. The client will then sign the appropriate section of the form to either indicate satisfaction or dissatisfaction with the outcome.
13. When the client is not satisfied with the outcome, the Clinical Director will forward the grievance to the CCO for further review and final resolution, within the 15 business days. The CCO will document all actions taken on the resolution form. It is the CCO's responsibility to try to resolve the concerns to the satisfaction of the client within the 15-business day time limit.
14. The CCO will discuss the findings of the resolution request form with the client. The client will indicate either their satisfaction or lack of, by signing in the appropriate section of the grievance form.
15. If the client remains unsatisfied, the client may request a formal hearing, which would include members of the Leadership Team, including any staff directly related to the program of origin.
16. The formal hearing will be scheduled to accommodate the client and/or family. A panel of Leadership team members will hear the case. Both client and staff may present information to assist in finding an appropriate and fair outcome.
17. The results of the appeal/formal hearing will be appropriately documented on the space available on the Resolution Request Form.
18. Once completed, the original completed document will be forwarded to the Director of Quality Services to retain.
19. All resolution requests resolved or otherwise, are reviewed at the Leadership team in their team meetings. The Leadership Team may make further recommendations that are consistent with the satisfaction of the client.
20. To provide written verification of the outcome of the resolution, either the copy of the Resolution Request Form, with all actions documented, may serve or the supervisor will send a letter to the client and, when appropriate, family, summarizing the findings and outcomes of the resolution request. The letter will state whether the outcome was acceptable or unacceptable to the client and family.
21. Resolution reviews will be included on each Leadership team meeting agenda. All Resolution Request forms are reviewed by the Leadership team.
Please note the following phone numbers if you would like to get further assistance.
Indiana Disability Rights: 800-622-4845
Indiana Child Abuse and Neglect Hotline: 1-800-800-5556
Adult Protective Services Hotline: 800-992-6978
Indiana Department of Mental Health Agency: 800-901-1133

Date *

Month Day Year

Client Rights

The following are your rights as a client who has elected to receive services from Inspire Counseling & Support Center 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 the 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 Director.
14. Your records are protected under state and federal confidentiality laws, which prohibit unauthorized 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 Massachusetts Department of Mental Health Agency: 617-624-6000
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:

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 be deprived of any constitutional rights.

Right to non-discriminatory services - Inspire Counseling & Support Center may not deny a client access to counseling services solely based on race, gender, ethnicity, age, sexual orientation, human immunodeficiency virus status, prior service departures against medical advice, disability or number or relapse episodes. Inspire Counseling & Support Center may not deny a client who takes medications, prescribed by a physician, access to services solely on that basis. Inspire Counseling & Support Center, 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 the client.

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 (Inspire Counseling & Support Center does not use restraints), the use of seclusion, the use of time-out, and other behavior management techniques.

Right to communication - Each client has the right to communicate freely and privately with other persons within the limitations imposed by Inspire Counseling & Support Center 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. Inspire Counseling & Support Center 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 Inspire Counseling & Support Center to inform the client and his/her family, if applicable, at the time of admission about Inspire Counseling & Support Center rules relating to communications and correspondence. This is included in the Client Orientation process.

Rights to care and custody of personal effect of clients - A client has the right to possess clothing and other personal effects. Inspire Counseling & Support Center 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.

Right to confidentiality of client records - The client records of Inspire Counseling & Support Center 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. Inspire Counseling & Support Center 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

Inspire Counseling & Support Center 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.

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 afford one.

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.

Liability and immunity - Any Inspire Counseling & Support Center 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.

Provisions – Inspire Counseling & Support Center 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. Inspire Counseling & Support Center 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 modification. 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:
(1) Mental health services or developmental training:
(A) in accordance with standards of professional practice;
(B) appropriate to the patient's needs; and
(C) designed to afford a reasonable opportunity to improve the patient's condition.
(2) Humane care and protection from harm.
(3) The right to practice the patient's religion.
(4) Contact and consultation with legal counsel and private practitioners of the patient's choice at the patient's expense.

Clients have the right to be fully informed before or upon admission about their rights and responsibilities and about any limitation 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.
▪ 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 reasonable hours.
· If residential services are provided, persons supported have the right to be given privacy and freedom in the use of their bedroom/sleeping area.

By signing below, I agree that I have read the client rights policy.

Date *

Month Day Year

Abuse Reporting Policy

Indiana law requires any person to report child abuse (Ind. Code 311-33-5 et seq.) or endangered adult abuse (Ind. Code 12-10-3-2 et seq.) to the Department of Child Services or Adult Protective Services. Physicians must report firearm injuries and life-threatening stab wounds (Ind. Code 35-47-7-1). Mental health service providers must report certain violent threats made by their patients (Ind. Code 34-30-16-2).

Indiana Child Abuse and Neglect Hotline: 1-800-800-5556
Adult Protective Services Hotline: 1-800-992-6978

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 clients 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 office is open Monday thru Friday from 8:00a-6:00p. 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 contact 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 hours 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
Indiana 211: 211
NAMI Indiana: 800-677-6442
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.

Health Screening

Information supplied by *

- ○ Self
- ○ Other (specify name and relationship below)

If other, name and relationship

Weight *

Height *

Recent Immunizations (Tetanus, flu, pneumonia, etc.)

Allergies (Environmental, food, medication, etc.)

Females Only: Date of last menstrual period

Month Day Year

- ○ Menopaus
- ○ Post Menopause

Do you have any of the following (please check all that apply)

- ☐ Unsteady walks or falls
- ☐ Ringing in the ears
- ☐ Fractures/dislocations
- ☐ Arthritis/back/neck problems
- ☐ Heart problems/Chest pains
- ☐ Heart murmur
- ☐ Ankle/Leg swelling
- ☐ Blood pressure problems
- ☐ Peripheral vascular disease
- ☐ Difficulty breathing/asthma
- ☐ Chronic bronchitis/emphysemia
- ☐ Lung problems
- ☐ Swallowing probelms
- ☐ Nausea/vomiting
- ☐ Weight gain/loss last 6 months
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Gastrointestinal problems
- ☐ Ulcer/rectal bleeding
- ☐ Kidney/urinary problems
- ☐ Stroke/seizure/severe headach
- ☐ Dizziness/blackouts/fainting
- ☐ Mental illness
- ☐ Hepatitis/jaundice
- ☐ Mononucleosis
- ☐ Tuberculosis
- ☐ Sexually transmitted infections
- ☐ Cancer
- ☐ Cold/sore throat/sinusitis
- ☐ Bleeding disorders/anemia
- ☐ HIV/AIDS
- ☐ Other (please specify below)

Other

Name of primary care physician

Date of last physical

Month Day Year

May we contact your doctor to request further information about your medical condition? *

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

Communicable Diseases

I understand that The Transition House, Inc. dba Inspire Counseling & Support Center may be obligated by law to report any instance of communicable diseases to designated local, state, or federal entities.

Physical Health Wellness

If you have not seen a primary care physician (PCP) in the last 12 months, we strongly suggest you make an appointment. If you do not have a PCP, your primary therapist can 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 may be asked to get lab tests done to test my medication levels (ex. lithium level). I understand it is my responsibility to follow through with the above recommendations.

Date *

Month Day Year

Emergency Procedure

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

Emergency contact name

First Name Last Name

Emergency contact relationship

Emergency contact address

Emergency contact phone #

Date *

Month Day Year

Payment Policy

Inspire Counseling and Support 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). The following fees are currently in place; however, they are subject to change.

- A $45.00 fee applies to all returned checks. No refunds will be provided for services already provided.
- 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/Adolescent Evaluation:
$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 - $3,550.00
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 pre-paid will be refunded too.

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 Inspire Counseling and Support Center.

Date *

Day Year

Guarantee of Payment

I, the undersigned, hereby agree to guarantee the payment of the bills for services rendered by The Transition House, Inc., dba Inspire Counseling & Support Center. 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 Inspire Counseling & Support Center. in accordance with the regular rates and terms of Inspire Counseling & Support Center. 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 Inspire Counseling & Support Center to the extent permitted by law, I hereby irrevocably assign, transfer and set over to Inspire Counseling & Support Center (I) all of my rights, title and interests to medical reimbursement, including but not limited to, (II) the right to designate a beneficiary, add a dependent, eligibility and (III) 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 Inspire Counseling & Support Center 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 Inspire Counseling & Support Center to pursue any such right of recovery. I hereby authorize the insurance company's) or third-party payers) to pay directly to Inspire Counseling & Support Center all benefits due for services rendered.

Date *

Month Day Year

- ◯ Mastercard
- ◯ Visa
- ◯ Discover
- ◯ American Express

Cardholder Name (as shown on card)

First Name Last Name

Card Number

Expiration Date

CVC Code (3 or 4-digit code on back of card)

Cardholder ZIP code (from credit card billing address)

Date

Month Day Year

Consent for Release

I, the undersigned authorize Inspire Counseling & Support Center 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 Inspire Counseling & Support Center to any insurance company, and/or third-party payers, or representatives providing coverage for this admission, or to any Inspire Counseling & Support Center representative. I acknowledge that this information may not be released to any other person or entity unless I authorized the Inspire Counseling & Support Center 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 Inspire Counseling & Support Center 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 Inspire Counseling & Support Center Representative the confidentiality of alcohol and drug abuse client records are protected by federal law regulations. Therefore, I understand that Inspire Counseling & Support Center may not disclose information to anyone outside of Inspire Counseling & Support Center, 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 Inspire Counseling & Support Center 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.

I, the undersigned hereby authorize free exchange of medical record information, including but not limited to the release of client information indicated above, between Inspire Counseling & Support Center 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 Inspire Counseling & Support Center 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 Acknowledgment

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 Inspire Counseling & Support Center 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 advance directive
- ☐ No, I do not have a psychiatric advance directive

Date *

Month Day Year

Telehealth

Telehealth services can be a great alternative for clients who struggle with mobility, transportation, or severe social anxiety concerns. After the completion of the evaluation appointment the therapist and you

can further discuss the appropriateness for continued treatment via telehealth.

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.

Telehealth Emergency Contact Information

Name

First Name Last Name

Date *

Month Day Year

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

1. All clients will be informed of and will attest via signature their receipt of Inspire Counseling and Support Center's attendance policy.
2. At the outset of treatment, the admitting clinician will verbally review the attendance policy with all clients and/or their guardians.
3. A signed copy of the intake packet, inclusive of the attendance policy will be attached to each client's electronic health record file.
4. 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.
5. All scheduled individual psychotherapy or other similar individual services will receive a telephonic reminder call the day prior, reiterating the appointment date and time.
6. 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

1. 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).
2. Clients will be given a 15-minute grace period to arrive for their appointment. Arrival after 15 minutes will be considered a no-show.
3. 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.
4. 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.
5. 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 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.

Date *

Month Day Year

Medication Services

Client Name *

First Name Last Name

Date of Birth *

Month Day Year

ONRISE

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.

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:
1. Lifestyle changes first (including a healthy diet, exercise, limited substances, and decreasing stress).
2. 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.
3. 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:
1. 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.
2. Any client receiving medication management through Inspire Counseling & Support Center must have at least one therapy session per month with a therapist.
3. 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.
4. 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

Our Indianapolis office has a therapy dog in training, Tank. He frequently will greet and interact with visitors in the office upon arrival and he may also attend individual or group therapy sessions with his handler. While animals can bring a lot of happiness, a sense of calm, and support, we acknowledge not everyone is comfortable in interacting with animals. At times, a dog's playful nature and barking as their form of communication can create stress and anxiety. Please review the consent form below to provide information about your comfort level before you arrive to our office.

Pet Therapy Consent Form

Animals can be vital in terms of therapy and treatment. It helps in one's emotional, developmental, motivational, or psychological concerns. Thus, we believe that pets, as friendly as they are to humans can be a very essential part of therapy. Although their behavior cannot be predictable always. So we would like to provide you with information with regard to the risks with the help of pets.
Our pets are trained or in training. Generally, animals have their own natural defenses. Thus, it is necessary to always keep in mind precautionary measures to prevent injuries such as getting scratched or bitten. All animals on property have all the appropriate vaccinations and are vetted for good temperament and are either certified with the Canine Good Citizen or Pet Therapy Certification or are actively working towards it.
Not all bites may be due to responses to defense or threat. Animals often use their mouths for playing. Therefore, there will be instances of playful biting to occur. Playful biting would mean that you may feel the pet's teeth but gentle ones. They don't intend to bite down to do harm, especially puppies.
Animals use their bodies for communication. They may lean on and brush their bodies against a person or show the wagging of their tails as a sign of interest. These may lead to happily aggressive behavior that may cause injury.
Our pets are screened with updated vaccinations before coming into the facility, but it is normal as well for them to carry diseases. In such cases, there is a very small risk that you might contract a disease.
Some people are allergic to fur or hair of animals. Please let me know if you have allergic reactions to any animal.
Animal Welfare
Animals have individual rights. Animal rights advocates believe they should be treated equally as members of the moral community and should be treated humanely and without unnecessary suffering. They should be treated gently or in some other way that would not appear uncomfortable.
Acknowledgment
By signing this form, you are hereby declaring your understanding and accept the rules and regulations of the institution as well as the guidelines set forth in the care and
responsibilities of animal-assisted therapy. You are fully releasing the Institution from any liability or damages, should any occur during the period of therapy with the help of pets. You understand the benefits and risks involved in the method of animal-assisted therapy treatment and accept the full liability in event that the therapy animal

inadvertently harms you or your child during the course of treatment.

*

○ I am of legal age and have the full capacity to give my consent to animal-assisted therapy

- ○ I am the legal representative/guardian of the above-named patient. I am signing this form on his/her behalf, as an express consent given by him/her for his/her benefit
- ○ I am declining participation with any animal-assisted therapy

I hereby declare that I understand and acknowledge the information above. I have had the opportunity to ask questions which answers were given to me to my satisfaction. I accept the terms and conditions of this consent and I assume all the risk that attaches herewith.

Name *

First Name Last Name

Email

Date *

Month Day Year

Name of legal guardian/representative

First Name Last Name

Email

Date

Month Day Year