TenderTouchCounselingServices

CARING FOR OTHERS IS NOT OUR JOB, IT'S OUR PASSION.

IDENTIFYING INFORMATION:

Consumer's Full Name: Last:_____First:_____Middle:_____

Date of Birth:_____Age:_____Gender:_____Social Security Number:_____

Medicaid Number:_____Medicare Number:_____Other Insurance:_____

Assignment of Benefits: I hereby authorize and assign payment to this facility and/or independent contractors of any type of reimbursement or payment due from Medicare, Medicaid or any other third party payor, for any and all cost incurred for my medical and related care at this facility and/or by the independent contractors providing services at this facility. I also authorize release of information concerning my treatment at Tender Touch Counseling Services, LLC, for the purpose of billing to the named insurance company.

Payment for Medical and Related Care: I agree to pay the charges incurred for the care I received as ordered by my physician(s) at this facility, including charges by independent contractors (such as radiologists and anesthesiologists) I guarantee full payment of all charges unless restricted by Medicare, Medicaid or contractual arrangement between my insurance company and this facility . Fee/Copay:_____

Signature:_____Date:_____

Race/Ethnicity: ☐ Black/ African American ☐ Hispanic/Latino ☐ Caucasian ☐ Asian
☐ American Indian ☐ Multiracial ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Language:_____Other Language:_____

Address:_____City:_____

Zip Code:_____County:_____

Phone:_____Alternate Phone:_____

Parent/Legal Guardian:_____Relationship to Consumer:_____

Address: (If different than above) _____

LIST BELOW ANY SERIOUS RECENT OR ONGOING MEDICAL CONDITONS

_____

_____

_____

EMERGENCY CONTACTS

Primary Contact Name:_____Relationship to Consumer:_____

Phone Number:_____Alternate Contact Number:_____

OTHER IMPORT ANT CONTACT NAMES & PHONE NUMBERS FOR RELEASE OF INFORMATION

Primary Care Physician Name and Phone Number:_____

Probation Officer Name and Phone Number:_____

DFCS Worker Name and Phone Number:_____

Other Name and Phone Number:_____

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ADVANCE DIRECTIVES INFORMATION

The Patient Self-Determination Act

As of December 1, 1991 the provisions of the Patient Self-Determination Act became effective. This act requires that certain health care facilities participating in the Medicare or Medicaid programs provide clients with information regarding their rights under state law to make decisions regarding medical care. This includes the right to refuse treatment and to execute living wills, powers of attorney, and other advance directives addressing the provision of medical care and psychiatric care. Care will not be denied because an individual does not have an advance directive.

Psychiatric Advanced Directive

Psychiatric Advance Directives is a document that outlines the psychiatric care you would like to receive in the event you become unable to make the decision for yourself. Anyone with a severe and persistent mental illness should consider obtaining one. However, at the present time a psychiatric advance directive is not a legal document in the State of Georgia. There is a bill before the State legislature to make them a legal document.

Advance Directive

An advance directive is a written document, such as a living will or durable power of attorney for health care, that makes your wishes clear regarding your medical and psychiatric care if you become unable to communicate your decisions to your care provider.

Living Will

A living will is a written directive that lets you state what type of medical treatment you do or do not wish to receive if you are too ill or injured to direct your own care, up to and including withholding or withdrawing life saving and/or sustaining procedures. State law describes a specific kind of form that must be used in order for a living will to be valid. This form must be signed, dated, and witnessed.

Durable Power of Attorney for Health Care

A durable power of attorney, also known as a medical power of attorney, is a signed, dated, and witnessed legal document in which you designate a trusted person (an agent or attorney-in-fact) to make medical decisions for you if you become unable to make the decisions yourself. You can give your agent the authority to oversee the wishes you've set out in your health care declaration, as well as the power to make other necessary decisions about health care matters.

_____I currently have the following, and am providing TTCS staff with a copy:

- ☐ Advanced Directives for Medical Crisis
- ☐ Advanced Directives for Psychiatric Crisis

_____I do not have any Advanced Directives

If you are interested in obtaining an Advanced Directive you may contact:

The Georgia Mental Health Client Network
1-800-297-6146

National Mental Health Association (NAMl)
l-800-969-6642

You may go to Brazelon Center for Mental Health Law
202-467-5730

TTCS staff may not assist in the writing or witnessing of a Psychiatric Advance Directive

Signature:_____Date:_____

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CONSENT FOR TREATMENT FORM

Client Name:_____DOB:_____

I am requesting services from **TTCS** for the above named consumer. I apply for and consent to mental health and/or substance abuse services, crisis, evaluation and treatment services as are approved and recommended by the physician (or other appropriate staff) at **TTCS**

I understand the treatment team will consist of various levels of behavioral health professionals, including, but not limited to, medical professionals, licensed mental health professionals, master's level therapists, and mental health technicians.

Once admitted to the program, the consumer's status and progress will be reviewed as needed. A report or reports concerning the staffs findings will be available to probation court, social services and/or parent/guardian, upon request. The consumer and/or parent/guardian will sign a release of information form before any information can be released.

An Individualized Resiliency/Recovery Plan (IRP) will be developed which contains goals and desired outcomes that can be expected to be achieved in order to be able to move to less intensive community support services. I agree to work towards the goals and objectives as established in the IRP.

I understand the risks any time an individual or family participates in counseling may include disclosure of information that may have not been previously discussed, feelings surfacing that have not been previously expressed which might be stressful, but with the understanding counse'ling can provide consumers can gain skills to understand and cope with these feelings, make healthier decisions, and feel better.

I agree to provide accurate and complete information to **TTCS** for billing of the consumer's treatment and agree to update this information as changes occur. I consent to allow **TTCS** to bill my insurance for services provided.

I am aware that I may stop my treatment with **TTCS** at any time. The only thing I will still be responsible for is any outstanding financial responsibility. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I have read or have been read the CONSENT AUTORIZATION FOR TREATMENT & SERVICES. My signature below indicates I have been given the chance to have all questions answered regarding this information and have not been forced to sign this form. I understand and agree to all of the above.

Signature of Consumer:_____Date:_____

Signature or Parent, Guardian or Personal Representative:_____Date:_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this organization not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. In addition, it may be necessary for the health care professional to take steps for the client to be placed in a restricted hospital environment to ensure the safety of the client and of others.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse or neglect, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Other health care professionals must report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional' s actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed. Clients who are on probation, court ordered to treatment or referred by the Department of Corrections, Department of Human Resources or the county Probation may have waived certain rights to confidentiality when entering the treatment program.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Audio/Video Taping

In the event it becomes necessary to audio and/or video tape a client for treatment or supervision purposes, a specific consent form for the purpose of audio and/or video will be required. No recordings of any kind will be conducted without the expressed consent of the client.

Other Provisions

TTCS does not conduct research on any of their clients. Outcome measures, as it pertains to the effectiveness or non-effectiveness of the treatment services are collected and analyzed to ensure that the best quality treatment is provided. No personal information on any client is disclosed, nor can any client be identified by any of outcome information collected.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

Authorize for Disclosure of Information

The undersigned hereby authorizes TTCS and its staff to release or disclose information in the medical, business or clinical record of the patient of the following:

- Any private or public entity with which a claim is being filed for a (all or part) of the patient's charges, including any insurance carrier or compensation carrier or any of the respective agents, representatives, and claims processing personnel.
- Any attorney, collection agency or other persons or entities engaged in the collection ofresponsible party to TTCS.
- Any other healthcare professional staff providing needed care.
- Any person, corporation, public or private agency to the extent necessary for TTCS to obtain and/or maintain licensure, federal and/or state reimbursement for the provisions of health care services or clarification.
- Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review.
- Any TTCS employee or provider requiring information including patient identity and address in order to provide care and/or maintain the medical records.
- For any release beyond the scope of this consent, the patient will be asked to sign a Release of Information Form.

The information release may include diagnosis and treatment including, but not limited to mental and physical condition, drug/alcohol and other information requested to determine coverage, medical necessity and other benefits determination.

This authorization may be revoked at any time except to the extent those actions have already been taken. To cancel this authorization, the patient and/or responsible party realizes that they must do so in writing and send it to TTCS.

Signature of Client:_____Date:_____

Signature of Parent / Guardian (if applicable):_____Date:_____

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AUTHORIZATION TO COMMUNICATE WITH THIRD PARTIES

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members or friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information we can communicate about you with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name).

Please list below any persons you will allow us to talk with about you. (If you prefer we do not speak with anyone, please write "NO ONE" across this section.

Name	Relationship	Phone Number	Restrictions (as defined above)

Authorization for Forms of Communication

Secure and private communication cannot be fully assured utilizing cell/smart phone (calls and text) or regular email technologies. Due to the nature of our services, staff and clients often communicate using cell phones for calls, voicemail, and text messaging. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Your use of any non-secure technologies to contact TICS office or staff will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change. In the event in which the company or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional' s first name only.

Please check where you may be reached by phone/text/mail. Include phone numbers and how you would like us to identify ourselves when phoning you.

_____HOME Phone number:_____

May we say the clinic name? ☐ Yes ☐ No

_____CELL Phone number:_____

☐ Calls ☐ Text

EMERGENCY Phone number:_____

May we say the clinic name? ☐ Yes ☐ No

INFORMATION CAN BE MAILED TO _____

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize TCCS staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

Signature of patient/guardian:_____Date:_____

TenderTouchCounselingServices

CLIENT RIGHTS & RESPONSIBILITIES

Receipt and Acknowledgment of Notice

Your rights as a consumer, including confidentiality of your participation in evaluation and treatment services, will be observed in accordance with O.C.G.A. 37-3-166, 37-4-125, 37-7-166, DHR Rules and Regulations for Consumer Rights, Chapter 290-0-9; 42 U.S.C. 290dd-2,and TICS Consumer Rights and Responsibilities Policy #2330, TTCS program policies and any other applicable laws, regulations, and policies, including the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. A summary of these rules and regulations will be reviewed with you and are available for inspection at each service location. You also will be provided a copy of the TTCS HIPAA Privacy Notice. This information will be reviewed on an annual basis with you.

Every program participant at TTCS has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. TICS is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

YOU HAVE THE RIGHT:

1. To services without discrimination on account of race, religion, sex, ethnicity, age, sexual orientation, disability or cultural background.
2. To exercise all fundamental human, civil, constitutional, and statutory rights to which you are entitled as a legally competent citizen unless such rights are limited under due process of law.
3. Informed consent or refusal or expression of choice regarding: service delivery, release of information, concurrent services, composition of service delivery team, involvement in research projects.
4. To be treated in a manner that respects your individual dignity and protects your health and safety at all times.
5. Be fully informed about the course of your care and decisions that may affect your treatment
6. Revoke your consent for treatment at any time
7. Timely and accurate information to assist you in making sound decisions about your treatment
8. Be fully involved as an active participant in decisions pertaining to your treatment
9. Have an individual identified in writing that will direct and coordinate your treatment. Consumers served have the right to access guardians, self-help groups, advocacy services and legal services at any time. Access will be facilitated through the person responsible for the consumer's service coordination
10. Request a change in individual directing and coordinating our treatment, if you so desire
11. Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial exploitation , (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and (e) all forms of seclusion and restraint
12. Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
13. File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort
14. Investigation and resolution of alleged infringement of rights.
15. Have family members, friends or others involved in your treatment with your consent and approval
16. Receive services that comply with all applicable federal and state laws, rules and regulations
17. File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit
18. To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences. Consumers served have the right to request and receive outside (other than TTCS. employees) professional consultation regarding their treatment at their own expense.
19. You may also have additional rights afforded to you based on federal, state, and local regulations. Your service coordinator will advise you of any additional rights that you may have.
20. To be informed of the benefits, side effects and risks of psychotropic medications in a manner and language that you can understand.
21. The right to review and obtain copies of your records for a fee by contacting your team leader. Disclosure of psychotherapy notes that your physician or authorized staff feel is not in your best interest may be excluded (Georgia Code 31 -33-2). If access of any information is denied, you have the right to have the denial reviewed by another licensed professional identified by TTCS.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY PRIVACY PRACTICES

1. To access or inspect your health care information unless a physician determines that the record review would be detrimental to your wellbeing.
2. To obtain a copy of your health care information for as long as the information is retained. (A reasonable fee may be charged for copying.)
3. To request in writing that TTCS and its programs restrict the use and disclosure of your confidential health care information.
4. To receive a copy of the notice of the TTCS HTPAA privacy practices.
5. To make a reasonable request in writing to receive phone, written or e-mail communications from TTCS. and its programs by alternative means or locations.
6. To request a list of when and to whom your health care information was released without your authorization within 6 years of your request for non-routine disclosures made on or after April 14, 2003.
7. To request an amendment to your health care information.

CONSUMERS' RESPONSIBILITIES

AS A CONSUMER OF TTCS AND ITS PROGRAMS, IT IS YOUR RESPONSIBILITY:

✓ To show consideration and respect towards staff, other consumers and the property of others.

✓ To provide accurate information of past and present complaints, past illnesses and hospitalizations, medications, and any perceived risks in your care and unexpected changes in your condition.

✓ To meet financial obligations agreed to with TTCS and its programs.

✓ To participate in developing your individualized resiliency/recovery/treatment or service plan including expressing any concerns about your ability to follow the proposed care plan and to ask questions when you do not understand.

✓ To take medications as prescribed.

✓ To accept the consequences of not following the treatment and service plan.

✓ To support the program by participating to the best of your ability and by being on time for all scheduled appointments and activities.

✓ To comply with the rules of the service location.

✓ To respect the confidentiality, privacy, and property of others who are receiving services with you.

✓ To report changes in your condition to those responsible for your care and welfare.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Attn: Felicia Briddy, TICS, 1475 Hwy 20 West, McDonough, GA 30253. (678) 782-6170.

You may also contact the Division's Privacy Coordinator by telephone at (404) 657-6423, facsimile (404) 657-6424, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia 30303-3142, for further information about the complaint process or this notice. **You will not be penalized for filing a complaint.**

I have read the above summary of Consumers' Rights & Responsibilities and have been given the opportunity to ask questions and

have been given a copy of this form. I have been offered a copy ofTTCS and its programs' HIP AA Notice of Privacy Practices.

Signature of Consumer:_____Date:_____

Signature of Legal Guardian or Representative:_____Date:_____

TenderTouchCounselingServices

RESTRICTIVE INTERVENTION

Receipt and Acknowledgment

TTCS works with adults presenting with a variety of emotional and behavioral needs. In the rare instance that a client presents high risk behaviors which could result in self harm or harm to others, TTCS staff members are required to summon external law enforcement personnel for the safety of all.

Purpose

The purpose of this document is to assure that you have an understanding of the policy staff members are required to follow in the event a consumer becomes violent or threatening. It is the policy of TTCS to have a zero tolerance policy of aggressive or threatening behavior in all locations, including offsite, home and community settings. TTCS will use a series of least restrictive alternatives to refrain from using any kind of seclusion or restraint as a behavioral intervention in the course of treatment for any client, however as a last resort option to protect the safety of the client, other clients present, and staff members TTCS may use verbal crisis de-escalation techniques. The organizational safety policy on violent and aggressive behavior, which directs staff to summon external law enforcement personnel, is followed in behavioral emergencies.

Procedures

TTCS shall provide services/supports that promote a safe and respectful environment. These include:

1. using the least restrictive and most appropriate settings and methods;
2. promoting coping and engagement skills that are alternatives to injurious behavior to self or others;
3. providing choices of activities meaningful to the clients served/supported; and
4. sharing of control over decisions with the client/legally responsible person and staff.

Staff members will use crisis de-escalation techniques as taught during their orientation process and other appropriate interventions approved by TTCS.

Signature of Consumer:_____ Date:_____

Signature or Parent, Guardian or Personal Representative:_____ Date:_____

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TRANSPORTATION AUTHORIZATION FORM

By signing below, I authorize TTCS staff members to transport

Client Name:_____

for the following reason (s): Medical, Recreational, Legal and Treatment related activities, during the specified course of treatment.

_____

Name of Agency/Organization: TTCS

I acknowledge that transportation is voluntary and during transportation the staff member will not knowingly or intentionally place my clients in danger and will notify or seek emergency assistance if unforeseen circumstances occur that require any such public emergency official services.

Consumer:_____Date:_____

Parent/Guardian:_____Date:_____

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CONSUMER ORIENTATION CHECKLIST

NAME:_____DOB:_____

As a client ofTTCS, I have received and understand the following components of client orientation:

_____An explanation of TTCS Mission, Vision, and Values.

_____Information on how to contact and locate TTCS facilities and staff.

_____An explanation of TTCS hours of operation.

_____An explanation of how to access the crisis center after hours of operation.

_____Information on how to contact the Georgia Crisis and After Hours Crisis Line.

_____An explanation of TTCS services and activities.

_____Familiarization of the clinic site, including emergency exits and/or shelters, fire extinguishers, fire alarms, and first aid kits.

_____An explanation of TTCS policies regarding the use of seclusion and restraint, special treatment and safety measures, smoking, and illicit/licit drugs and weapons brought onto TTCS property.

_____An explanation of my rights and responsibilities.

_____An explanation of TTCS expectations regarding my treatment.

_____An explanation of when rights may be restricted.

_____An explanation ofTTCS confidentiality policy and Privacy Notice.

_____An explanation of the grievance and appeal procedures.

_____An explanation of TTCS Code of Ethics.

_____An explanation of any and all financial obligations, fees, and financial arrangements for services provided.

_____If appropriate, education regarding advance directives.

_____An explanation of ways in which I can provide input to the quality of my care, achievement of my treatment outcomes, and satisfaction of the services provided.

_____A description of how the individual service plan will be developed with my participation.

_____If mandated by a court of law to receive treatment, an explanation of the requirements for follow-up regardless of the discharge outcome.

_____When applicable, an explanation of TTCS's services and activities regarding (1) expectations for consistent court appearances and (2) identification of therapeutic interventions including sanctions, interventions, incentives and administrative discharge criteria.

_____An explanation of the use of electronic communication.

_____Information regarding discharge or transition criteria and procedures.

_____EDUCATIONAL INFORMATION ON HIV/AIDS, TB, Hepatitis & Other Infectious Diseases

Client Signature:_____Parent/Legal Guardian Signature:_____

Date:_____