Caring Hearts Professional Counseling Services, LLC

Patient Information

(Please Print All Information)

Date: _____ Time: _____

PATIENT INFORMATION

Name *(First, Middle Initial, Last)*: _____

Age: _____ Date of Birth: _____ SSN#: _____ Race: _____

Street Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

School: _____ Phone: _____

Grade: _____ Teacher: _____ Religion: _____

LEGAL GUARDIAN INFORMATION

Name *(First, Middle Initial, Last)*: _____

Relationship to Patient: _____

Date of Birth: _____ SSN#: _____ Email: _____

Street Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____

Employer Address: _____

City/State/Zip: _____ Occupation: _____

Work Phone: _____ Other Phone: _____

EMERGENCY CONTACT

Name *(First, Middle Initial, Last)*: _____

Relationship to Patient: _____

Street Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Name *(First, Middle Initial, Last)*: _____

Relationship to Patient: _____

Street Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Policy Holder Name: _____

Date of Birth: _____ SSN#: _____

Policy Holder's Relationship to Patient: _____ ID Policy #: _____

Group #: _____ Group Name: _____

Secondary Insurance: _____ Phone: _____

Policy Holder Name: _____

Date of Birth: _____ SSN#: _____

Policy Holder's Relationship to Patient: _____ ID Policy #: _____

Group #: _____ Group Name: _____

Third Insurance: _____ Phone: _____

Policy Holder Name: _____

Date of Birth: _____ SSN#: _____

Policy Holder's Relationship to Patient: _____ ID Policy #: _____

Group #: _____ Group Name: _____

DHS/OJA INFORMATION

DHS _____ OJA _____

Caseworker Name: _____

Work Phone: _____ Cell Phone: _____ Email: _____

Address: _____

City/State/Zip: _____ County: _____

Supervisor Name: _____

Work Phone: _____ Cell Phone: _____ Email: _____

County Director Name: _____

Work Phone: _____ Cell Phone: _____ Email: _____

CURRENT MEDICATION INFORMATION

Name of Medication	Start Date	Dosage	Times Given	Prescribing Physician
PREVIOUS MEDICATION ***(If different within the last 12 months)***				

ALLERGY INFORMATION

Food Allergies: _____

_____

Medication Allergies: _____

_____

MEDICAL INFORMATION

Does patient have any significant medical conditions that require on-going monitoring? YES _____ NO _____

If yes, please explain _____

_____

_____

DRUG/ALCOHOL USE

Has patient used any illicit drugs or alcohol in the past 24 hours? YES _____ NO _____

If yes, please explain _____

_____

_____

PREVIOUS/CURRENT PROVIDER INFORMATON

Primary Physician: _____ Phone: _____ Agency/Clinic: _____

Psychiatrist: _____ Phone: _____ Agency/Clinic: _____

Therapist/Counselor: _____ Phone: _____ Agency/Clinic: _____

SIGNATURES

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Client Orientation Checklist

Client or responsible party must initial each that are true and sign at the bottom.

_____ I Have received and understand a copy of the Patient's Bill of Rights.

_____ I Have received and understand a copy of the Client's Grievance Policy.

_____ I Have received and understand a copy of the Client's Handbook.

_____ I Have received and understand an Orientation to the program, the facility and the staff who were available.

_____ I understand that if I have any questions at any time, I simply have to ask.

_____ I understand that while I am receiving services with Caring Hearts Professional Counseling Services, LLC that I will receive the services that I am approved for, want and need.

_____ I understand that I am expected to actively participate in my therapy and if I choose not to participate, I may be discharged.

Client Name *(Please Print)*: _____

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Authorization to Release/Request Individual's Health Information/Treatment

Name *(First, Middle Initial, Last)*: _____

Other Names Used: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

I hereby authorize and request access to the protected health information in my health record, from _____ to _____ maintained or created by the provider named below to the recipient named below.

- ☐ Psychotherapy Notes
- ☐ School Reports
- ☐ Mental Health Records
- ☐ Discharge Summaries
- ☐ Billing Records
- ☐ HIV/STD Records
- ☐ History and Physical
- ☐ Medical Reports
- ☐ Alcohol or Drug Abuse Records
- ☐ Lab Work
- ☐ Assessments
- ☐ Other _____

☐ I will pick up the copies of my records

☐ Mail copies of my records to the individual noted below

Records from Provider	Records to Recipient
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

Purpose of Request:

☐ Patient's Request ☐ Dispute ☐ Referral ☐ Other: _____

I understand:

- I or my legally authorized representative may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be twelve (12) months from the date of signature.

- Unless the purpose of this Authorization is to determine payment of a claim or benefits, Caring Hearts Professional Counseling Services, LLC may not condition the provision of treatment or payment for my care on my signing this Authorization.

- Treatment Services are not contingent upon or influenced by the consumer's decision to permit the information release.

- For non-client information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulation. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99.

- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE

- **The information authorized for release also includes protected health information related to mental health. Release of mental health records or psychotherapy notes may require the consent of the treating provider or a Court Order.*

- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

**May be requested to show proof of representative status*

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Complaint/Grievance Policy

Caring Hearts Professional Counseling Services, LLC maintains a policy by which a client may make a formal complaint, file a grievance, or appeal a decision made by the organization's personnel or team members.

1. A client making a formal complaint or filing of a grievance or appeal will not result in retaliation or barriers to services.
2. All reasonable efforts will be made to resolve the grievance on the client's behalf. Efforts used may include review and interpretation of policy and procedures, questioning of staff and clients, review of physical evidence, mediation and/or other means necessary for resolution.
3. Lily Williams, CEO of Caring Hearts PCS, LLC is responsible as the local advocate and coordinate of the grievance policy. Complaints, grievances, and appeals should be in writing and submitted to Lily Williams. If a client is not satisfied with the outcome of his/her grievance, it may be appealed to Caring Hearts PCS, LLC local advocate and coordinator. A final appeal available can be made by the client to the ODMHSAS Advocate General.
4. The local advocate and coordinator will respond to the complaints, grievances, or appeal within 7 days of receiving the formal written complaint.
5. If a client is not satisfied with the outcome of his/her grievance, it may be appealed to Lily Williams, who will provide a final response with 72 hours of the appeal, excluding weekends and holidays.
6. The final appeal available to the client is to the ODMHSAS at:

   The Department of Mental Health & Substance Abuse Services, Client Advocate Division

   Email: advocatedivision@odmhsas.org

   Toll Free: 888-699-8605 Local: 405-521-4256
7. Written notice of the procedure is provided and explained at the time of admission to the client and if involved with the client, to the family members of significant others. The procedure is posted in the client care areas of the outpatient offices.
8. The rights and responsibilities of each party have been defined in the above procedure.

9. The client has the right to make a formal complaint without fear of retaliation and can appeal the decision to higher levels with the organization and with the ODMHSAS. The client must provide the complaint in writing to the CEO.

10. Lily Williams, CEO of Caring Hearts PCS, LLC, must and will make every responsible effort to resolve the issue or complaint, investigate and communicate a decision within 7 days of receiving the written complaint.

11. The local advocate and coordinator must provide a final response within 72 hours, if the client appeals the decision.

12. A consumer shall have unimpeded and confidential access to the facility's local advocate and the ODMHSAS Office of Consumer Advocacy.

13. Caring Hearts PCS, LLC, will also ensure the availability of the advocates and other assistance is made available to each client if the complaint or grievance is directed towards administration.

14. If the complaint is against the local advocate/coordinator authority shall be delegated to the Office Manager. If the client/consumer requests to issue a complaint without the inclusion of Caring Hearts PCS, LLC, a grievance may be issued directly to ODMHSAS at:

    The Department of Mental Health & Substance Abuse Services, Client Advocate Division

    Email: advocatedivision@odmhsas.org

    Toll Free: 888-699-8605 Local: 405-521-4256

15. Complaint procedures and applicable forms are readily available and understandable to the persons served.

Caring Hearts Professional Counseling Services, LLC

Consent for Survey and Follow-Up

Client Name: _____

SURVEYS

As a participant in the services offered by Caring Hearts Professional Counseling Services, LLC, you will be asked to provide formalized feedback from time to time. The purpose of these surveys is to provide Caring Hearts Professional Counseling Services, LLC, with information on how to improve our services. You are in no way obligated to fill out the surveys and they are anonymous.

I understand that my treatment does not depend on my agreement to participate. My participation is strictly voluntary and I am free to withdraw my permission at any time.

☐ I **AGREE** and consent to participate in the Surveys

☐ I **DO NOT AGREE** and consent to participate in the Surveys

FOLLOW-UP

In addition, after you discharge from our services, we like to contact you. It is our way to make sure you are doing well and that you still value the services we have provided. Once again this is an opportunity for us to get feedback to improve our services

I understand that my treatment does not depend on my agreement to participate. My participation is strictly voluntary and I am free to withdraw my permission at any time.

☐ I **AGREE** and consent to Follow-Up

☐ I **DO NOT AGREE** and consent to Follow-Up

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Discontinuation of Other Services

I, _____ Medicaid

Number,_____ would like to discontinue receiving services from all

other agencies and providers effective_____.

I would like to begin receiving services from **Caring Hearts Professional Counseling Services, LLC**

beginning on_____.

Client Name *(Please Print)*: _____

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Exit Criteria

- You may choose to leave the program at any time.
- You may be asked to leave the program if you qualify or violate one of the following:
    - The client has achieved a good portion of their goals and is ready and willing to discharge.
    - Missing 3 consecutive appointments without notification.
    - Being under the influence of illicit drugs or alcohol during treatment.
    - Possessing illicit drugs or weapons during treatment.
    - Failure to participate in treatment, lack of progress or failure to follow a specific behavioral contract.
    - The person served moves or request to change provider.
    - A major change in the person served that merits a different type of treatment (Specialty schools that provide their own therapy, Job Core-etc.).
    - The need for more (or less) intensive services.
    - Physical violence.
    - Failure to pay fees.
    - Inappropriate sexual contact.
    - Destruction or damage to property.
- You may ask to be readmitted to the program by asking the treatment team, in writing, to reconsider your case. The clinical director has the final decision. You have a right to a decision within 15 days of the receipt of the written request.

Caring Hearts Professional Counseling Services, LLC

First Aid and Emergency Medical Care Consent Form

Client Name: _____ **Date:** _____

I acknowledge that all Caring Hearts Professional Counseling Services, LLC (Caring Hearts PCS, LLC) staff are not trained in First Aid and CPR and will not engage in the administering of CPR and/or First Aid if they are not trained to do so.

I understand that every effort will be made to contact me or my emergency contact in the event of an emergency requiring medical attention for myself/my child. In the event of an emergency requiring CPR and/or First Aid, Caring Hearts PCS, LLC will contact the appropriate emergency services to provide assistance.

1. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my/my child's safety; and,
2. I willingly agree to comply with the stated and customary terms and conditions for the First Aid and Emergency Medical Care.
3. I, HEREBY RELEASE, INDEMNIFY, AND HOLD HARMLESS Caring Hearts PCS, LLC their officers, officials, agents and/or employees, other participants and, if applicable, owners and lessors of premises used for the activity ("Releasees"), WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property associated with the First Aid and Emergency Medical Care policy, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

My signature acknowledges that a staff member of Caring Hearts PCS, LLC has explained and that I understand the content of this consent and the nature and types of treatment that will be provided and I have received a copy of the outpatient packet including copies of consent forms signed. I was explained in detail and understand the nature and details of the outpatient packet and consent forms as explained by Caring Hearts PCS, LLC.

Client Signature: _____ Date: _____

Signature of Guardian *(if Applicable)*: _____ Date: _____

Staff Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Grievance Statement

Remember, we encourage you to discuss any complaints or issues about your Mental Health services with your Service Provider or Coordinator. You may file a Grievance by talking to your Service Provider or Coordinator, or to any Mental Health staff with whom you feel comfortable. Also, you have the choice of completing this form, or phoning in your Grievance to either of the following people:

Safety Officer: Ramona Williams 918-409-9763

Consumer Rights Advocate:
The Department of Mental Health & Substance Abuse Services, Client Advocate Division
Email: advocatedivision@odmhsas.org
Toll Free: 888-699-8605 Local: 405-521-4256

Consumer Information	
Name	
Date of Birth	
Phone Number	
Address	
City/State/Zip	
Email	
Signature	
Date Submitted	

Describe the Grievance ***(Please include dates and names, if possible; Use Additional Pages if needed)***

Grievance Statement
(Please include dates and names, if possible; Use Additional Pages if needed)

Caring Hearts Professional Counseling Services, LLC

Non-Smoking Agreement

Caring Hearts Professional Counseling Services, LLC (Caring Hearts PCS, LLC) is committed to providing a safe and healthy workplace and to promoting the health and well-being of its clients. We desire to provide a healthy environment for our clients. The following smoking policy has been adopted and shall apply to all clients in treatment at Caring Hearts Professional Counseling Service, LLC.

POLICY

It is the policy of Caring Hearts Professional Counseling Service, LLC to prohibit smoking on all company premises to provide and maintain a safe and healthy environment for all clients in treatment. The law defines smoking as the "act of lighting, smoking or carrying a lighted or smoldering cigar, cigarette or pipe of any kind."

PROCEDURE

Smoking is not allowed in any part of the campus premises.

A formal review of the policy will be conducted during initial assessment and on a periodical basis during treatment.

Clients will be consulted over the results of this policy monitoring and review and will be offered resources and assistance to quite using tobacco products.

STATEMENT OF UNDERSTANDING

I have read and fully understand the terms of this policy.

I understand that Caring Hearts Professional Counseling Service, LLC reserves the right to make changes to this policy as may be required.

Client Name *(Please Print)*: _____

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

NOTICE OF CLIENTS' RIGHTS

1. Each consumer has the right to be treated with respect and dignity.
2. Furthermore: Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
3. Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
4. No consumer shall be neglected or sexually, physically, verbally, or otherwise abused. Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan.
5. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment.
6. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law.
7. Additionally, each consumer shall have the right to the following: Allow other individuals of the consumer's choice to participate in the consumer's treatment and with the consumer's consent;
    a. To be free from unnecessary, inappropriate, or excessive treatment;
    b. To participate in consumer's own treatment planning;
    c. To receive treatment for co-occurring disorders if present;
    d. To not be subject to unnecessary, inappropriate, or unsafe termination from treatment;
    e. To not be discharged for displaying symptoms of the consumer's disorder.
8. Every consumer's record shall be treated in a confidential manner.
9. No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law.
10. Refusal to participate shall not affect the services available to the consumer.
11. A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
12. Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
13. No consumer shall be retaliated against or subject.

Upon request you will receive a full copy of the Department of Mental Health and Substance Abuse Services rights.

At any time you may call:

ODMHSAS Consumer Advocacy Division
(866) 999-6605
(405) 521-4256

ODMHSAS Office Of Inspector General
(877) 426-4058
(405) 522-4058

ODMHSAS: Office of Consumer Advocacy
E-Mail: AdvocacyDivision@odmhsas.org
Reach out Hotline: (800) 522-9054

Client Name *(Please Print)*: _____

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Outpatient Consent For Treatment

Client Name: _____

Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Cell Phone: _____

SSN: _____ INS: _____

Please accept my signature as authorization for Caring Hearts Professional Counseling Service, LLC (Caring Hearts PCS, LLC) to provide outpatient mental health therapeutic services to me or my child.

I understand that outpatient services consist of regular and ongoing assessment, evaluation, and treatment provided by professionals employed by Caring Hearts PCS, LLC. I understand that I am an active participant in this treatment. I understand that I have the right to terminate services at any time and/or to receive these services from another provider.

The roles and responsibilities of mental health workers (including employees of Caring Hearts PCS, LLC) have been explained to me and I understand that they are mandated reporters of child abuse and neglect, whether visible or suspected as outlined in Oklahoma State Statue.

I understand that all information pertaining to this treatment is protected by State and Federal confidentiality guidelines and that no information pertaining to this treatment may be released without my expressed consent. However, I also understand that a mental health professional, with direct knowledge of an individual's intent to harm or otherwise put in danger another individual, has the duty to warn the third party who is likely to suffer the results of any harmful behaviors. Further, the mental health professional with direct knowledge of an individual's intent to harm him/herself has a duty to take steps to prevent such harm every effort will be made to resolve the issue before any breach of confidentiality takes place.

I further understand that if, in the course of treatment, the treating clinician suspects that I present for a session under the influence of drugs and/or alcohol, that session can be immediately ended with the clinician making all reasonable efforts to ensure my safety, which may include notifying my emergency contacts and/or the authorities of my intent to drive under the influence of drugs/alcohol. Further discussion of this incident would then take place during a subsequent visit.

My signature acknowledges that a staff member of Caring Hearts PCS, LLC has explained and that I understand the content of this consent and the nature and types of treatment that will be provided and I have received a copy of the outpatient packet including copies of consent forms signed. I was explained in detail and understand the nature and details of the outpatient and consent forms as explained by Caring Hearts PCS, LLC.

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Sliding Scale Payment

Some clients that do not have insurance or another payment source can qualify for sliding scale payment.

_____ No Thanks I have a payer source

_____ I am a private pay client and would like to see if I qualify for the sliding scale payment option.

_____	19,999 and below	-	$45.00
_____	20,000 to 29,000	-	$55.00
_____	30,000 to 49,000	-	$65.00
_____	50,000 and above	-	Not eligible

It is possible that a family may qualify for the sliding scale if the annual income is low and the number of members is high.

A formula for that situation is:

_____	an allowance of 10,000 per family member	-	$45.00
_____	an allowance of 15,000 per family member	-	$55.00
_____	an allowance of20,000 per family member	-	$65.00
_____	an allowance of25,000 per family member	-	Not Eligible

Hourly fee $_____

I have received a copy of this form and agree to the terms.

Client Name *(Please Print)*: _____

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____

Caring Hearts Professional Counseling Services, LLC

Treatment Advocate

All adult mental health consumers receiving services at Caring Hearts Professional Counseling Services, LLC shall be informed by staff that the consumer has the right to designate a family member or other concerned individual as a treatment advocate.

_____ I **DO NOT** wish to name a Treatment Advocate at this time

_____ I **DO** wish to name a Treatment Advocate at this time

My Treatment Advocate can have access to the following:

As the designated Treatment Advocate, I agree to the following:

A. Serve according to the consumer's specifications
B. Comply with all standards of confidentiality

No limitation may be imposed on a consumer's right to communicate by phone, mail or visitation with his or her Treatment Advocate, except to the extent that is reasonable times and places may be established. The Treatment Advocate may participate in the treatment planning and discharge planning of the person being served to the extent consented to by the consumer and permitted** by **law.

Client Name *(Please Print)*: _____

Client Signature: _____ Date: _____

Parent/Guardian *(If Applicable)*: _____ Date: _____

Treatment Advocate Signature: _____ Date: _____

Staff/Clinician Signature: _____ Date: _____