Welcome to Fresh Start Behavioral Health Intake Packet

Our mission is to provide effective and efficient data-driven services that result in sustainable change through professional case management, counseling, and educational services by highly qualified and dedicated professionals.

Please take this time to read the front and back pages of all the information printed in this folder. It contains several policies and procedures, as well as, detailing your medical information.

You will be required to print and sign your name on most of the pages.
Intake Process Flow Sheet

Please give this document to the intake person

Client Initial	Task	Page	Staff Initial
_____	Collect ID and Insurance Cards (make copies)		_____
_____	If Molina Insurance get Pre-approval		_____
_____	Read and Complete Packet		_____
_____	Provider Service Plan	3	_____
_____	Confidentiality 42 CFR part 2	7	_____
_____	Video Surveillance Consent Form	8	_____
_____	Consent for treatment for CD & MH	9	_____
_____	Financial Policy & Agreement	11	_____
_____	Intake Questionnaire	13	_____
_____	Telehealth Policy and Consent	21	_____
_____	Wellness Screening & Treatment (COVID)	23	_____
_____	Consent for Patient Email & Text Messaging	24	_____
_____	HIPPA Privacy Authorization Policy	27	_____
_____	HIPPA Authorization ROI	31	_____
_____	HIPPA Authorization Labs	33	_____
_____	HIPPA Authorization Pharmacy	35	_____
_____	HIPPA Authorization ROI	37	_____
_____	HIPPA Authorization PO	39	_____
_____	Treatment Structure & Protocol for M.A.T. Program	41	_____
_____	Controlled Substances Agreement/Informed Consent	43	_____
_____	**Receipt of and Understand of Information in Client Handbook (2 Weeks for intake Date)**	45	_____
	Diagnostic Assessment		
_____	CDA completed & signed		_____
_____	Therapist and group assignments made		_____
_____	MAT referral if needed		_____
_____	Case Management referral		_____
	Peer Support assignment		_____
_____	**See Nurse/MA for vitals, assessment and instant UDS**		_____
_____	**See the Doctor**		_____
_____	**Schedule case management assessment**		_____
_____	**Schedule Peer specialist assessment**		_____
_____	**Schedule any follow up visit's patient may need as well as Initial Mental Health Evaluation**		_____

All new patients must have Initial MAT and Initial mental Health evaluation

Provider Service Plan

Effective 4/10/2020

VISION: Client will experience lasting and sustainable change resulting in transformation.

MISSION: To provide effective and efficient data-driven services that result in sustainable change through professional case management, counseling, and educational services by highly qualified and dedicated professionals.

1. To provide the highest quality wraparound services to the client and client's support
1. system who may be involved with the client's recovery.
2. To include as many community stakeholders in the treatment process as possible without
3. violating client safety and confidentiality.
4. To provide the highest professional development opportunities to ALL staff members
5. To have an outstanding quality and continuous improvement program that manages ALL
6. Internal processes effectively.

OUTPATIENT TREATMENT SERVICES (LEVEL 1.0)

Referral and Information - FSBH will offer Referral and Information services to our community members who may be seeking SUD and/or mental health services through a process called "matching." Matching is a process of selecting treatment resources to conform to an individual client's needs and preferences, based on careful assessment. Matching has shown to increase treatment retention and thus to improve treatment outcome. It also improves resource allocation by directing clients to the most efficient and effective level of care and intensity of services. FSBH offers an extensive list of services providers offering various kinds of services to meet the needs of our community of stakeholders. Stakeholders have the options of coming into FSBH to inquire about services being offered or stakeholders may contact FSBH via telephone.

Assessment - Every client who enters FSBH will receive a comprehensive, integrated substance abuse and mental health assessment. The assessment can include collateral information from a variety of sources to include family members, legal guardians and/or significant others in order to obtain the extent of the client's alcohol and/or drug problem. A diagnostic assessment update is administered if a previous assessment is available from a program certified by Ohio Mental Health and Addiction Services or is an assessment containing comparable elements of assessment required by Ohio Administrative Code 3793:2-1-08, and has been completed within one year of the admission date of services.

Crisis Intervention - FSBH will provide crisis intervention to clients, family members, and or significant others to assist with alleviating a crisis or emergency situation. A thorough assessment of the crisis or emergency situation will take place to determine what happened during the crisis and how the client and or family members responded to the crisis. FSBH may contact additional support such as Crisis Care to further explore crisis situations.

Case Management - FSBH will provide case management services to our clients, family members, and/or significant others to assist with meeting essential services to help meet basic needs. Some

examples of case management services may include, housing assistance, food, clothing, medical services, and educational services, vocational and recreational services. Each client, family member, and/or significant other needing case management services will have a case management assessment completed to determine the exact needs of the client, family member, and/or significant other, and appropriate case management services will be provided by a case manager to further assist with stabilization and recovery.

Individual Counseling -FSBH provides each client with individual counseling at least once monthly. Clients who are in phases one and two have to have at least one individual counseling session weekly. Individual counseling can occur between the client, and family member or client and significant other of the client. Individual counseling means the utilization of special skills to assist an individual in achieving treatment objectives through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making and/or discussing didactic materials with regard to alcohol and other drug related problems. Individual counseling services can be provided at a program site certified by the Ohio department of alcohol and drug addiction services or in the client's natural environment.

Group Counseling - FSBH provides group counseling to clients in both the outpatient program and Intensive outpatient program. Group counseling for individuals who have progressed to phase three of the program are only required to attend one 90-minute group weekly. Group counseling means the utilization of special skills to assist two or more individuals in achieving treatment objectives. This occurs through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making and/or discussing information related to alcohol and other drug related problems.

Family Counseling - FSBH provides family counseling because we understand the effects of addiction are far reaching and clients' family members and loved ones also are affected by the disorder. By including family members and partners in the treatment process, education about factors that are important to the client's recovery (such as establishing a substance free environment as well as their own recovery can be conveyed. Family members and partners can provide social support to the client, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

Urinalysis - Urinalysis means the testing of an individual's urine specimen to detect the presence of alcohol and other drugs. Urinalysis includes laboratory testing and/or urine dip screen. ALL clients in outpatient, intensive outpatient, and maintenance programs will have to have urine screens weekly. Urine screens can be random or during set times during the week. Urine screens are an intricate part of the treatment process.

Medical/Somatic - FSBH will provide medical/somatic services by a State of Ohio licensed medical practitioner to include doctors, physician assistants, nurse practitioners, and nurse specialists. All practitioners' have to be waived by the Drug Enforcement Agency. FSBH'S medical practitioners Medical/somatic services means medical services, medication administration services, medication assisted treatment, and the dispensing of medications in an alcohol and other drug treatment program

INTENSIVE OUTPATIENT TREATMENT SERVICES (LEVEL 2.1)

Description of Services The program consists of nine hours of direct client/consumer contact per week which consists of a combination of services carefully crafted to deliver core recovery skills while additionally meeting individual needs in a flexible format. In addition to individual counseling, treatment planning, case management, drug screening analysis and crisis intervention (as needed), each client/consumer is involved in recovery-oriented didactic and experiential activities delivered in group counseling and group sessions. Through group counseling, and individual counseling, clients/consumers explore the core issues of addiction and recovery and gain valuable experiences while trying on new healthy attitudes and behaviors. This service typically lasts for sixteen weeks.

Below is a description of the specific services provided through the Intensive Outpatient Program:

Assessment - Every client who enters FSBH will receive a comprehensive, integrated substance abuse and mental health assessment. A diagnostic assessment update is administered if a previous assessment is available from a program certified by Ohio Mental Health and Addiction Services or is an assessment containing comparable elements of assessment required by Ohio Administrative Code 3793:2-1-08, and has been completed within one year of the admission date of services.

Groups - FSBH Clients participate in three weekly addiction awareness counseling groups. Each group lasts 3 hours and is structured around a recovery topic to help clients examine their use of alcohol, drug addiction (explore co-occurring disorders - behavioral health condition - if applicable) to begin making decisions about the value of a recovering lifestyle. The small counseling group format (1:12) provides a supportive environment that promotes sharing and disclosure so clients can learn from the experiences of other clients in the group.

Individual Counseling - FSBH Clients meet individually with their counselor as mutually scheduled to work on engagement, identification of individual recovery issues, treatment planning, case management needs, and affirmation of the clients' resolve and self-efficacy as well as to evaluate progress.

Crisis Intervention (as needed) - FSBH will provide crisis intervention to clients, family members, and or significant others to assist with alleviating a crisis or emergency situation. A thorough assessment of the crisis or emergency situation will take place to determine what happened during the crisis and how the client and or family members responded to the crisis. NHTS may contact additional support such as Crisis Care to further explore crisis situations.

Family Counseling - FSBH provides family. FSBH believes Family counseling means the utilization of special skills in sessions with individuals and their family members and/or significant others under the guidance of a counselor to address family and relationship issues related to alcohol and other drug abuse and/or dependence for the purpose of promoting recovery from addiction.

Days and Hours of Service: To be determined

Access to Services

Generally, FSBH exclusionary criteria includes the following: Individuals with severe and persistent mental illness, severe brain trauma leaving the person incapable of benefiting from treatment at this level of care, individuals under the age of 18, and individuals with long histories of violent behaviors. In all cases except minors, each case will be reviewed individually to determine whether the person might be appropriate for adult Intensive Outpatient Treatment Services.

Fresh Start Behavioral Health believes in transparency and accountability to all and this service plan shall be available for review by persons served, their family, significant others, and the public.

Services that may be offered through referral include:

Crisis Services-

Samaritan Behavioral Healthcare, Inc. (Crisis Care) (937)224-4646

Partial Hospitalization-

Eastway Behavioral Healthcare, Inc. (937) 496-2000
South Community Behavioral Healthcare, Inc. (937) 293-8300
Miami Valley Turning Point (937) 208-6719
Veterans Administration (Veterans only) (937) 268-6511

Residential Services:

Nova Behavioral Healthcare (937) 253-1680
Veterans Administration (Veterans only) (937) 268-6511
Women's Recovery Center (937) 562-2400

Ambulatory Detoxification:

Nova Behavioral Healthcare (937) 253-1680
Veterans Administration (Veterans only) (937) 268-6511

Confidentiality Policy and Procedure
Written Summary of Federal Regulation:
Confidentiality of Alcohol and Drug Abuse
and Mental Health Client Records

The confidentiality of alcohol and drug abuse client records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program or disclose any information identifying a client as an alcohol or drug abuser; unless:

1. The client consents in writing:
2. The disclosure is allowed by a court order;
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations

U.S. Attorney's Office
221 E. Fourth Street, Suite 400
Cincinnati, OH 45202

Ohio Department of Mental Health and Addiction Services
30 East Broad Street, 36th Floor
Columbus, Ohio 43215-3430

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

I acknowledge that I have received and reviewed the Fresh Start Behavioral Health Inc. Notice of Privacy Practices for Substance Use Patients, which includes particular information relating to the disclosure and us of information relating to substance use treatment.

Client Signature : _____ Date:_____

Video Surveillance Consent Form

I _____ (Client Name) have been informed that while a patient at Fresh Start Behavioral Health Inc that I will be under camera surveillance for my safety and protection. Camera surveillance will be utilized in the office and in the sober living homes.

It is the policy of Fresh Start Behavioral Health Inc that the camera surveillance is for therapeutic purposes and will be conducted upon consent of the patient and only with approved equipment.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Consent for treatment for mental health and chemical dependency services.

I hereby authorize Fresh Start Behavioral Health Inc. to utilize customary behavioral health treatment services, including chemical dependency, in providing care for:

_____

(Name of client)

These services will be provided by Fresh Start Behavioral Health Inc staff or consultants. I concur with the following: I have received the Client Orientation Handbook which includes, but not limited to, the statement of the Notice of Privacy Practices and Client Rights. I have accepted my initial fee agreement. I will participate in forming a plan for my child's / my own treatment as my signature on the individual service plan will affirm. Further, I understand that while counseling and other services provided by the agency offer reasonable expectation of benefit, there is no certainty of success. There may be minimal risk inherent in any psychiatric, psychological, or behavioral health counseling intervention and I can expect that any reasonable or anticipated risks will be discussed with me. I understand that it is my responsibility to inform Fresh Start Behavioral Health Inc service providers of any problems or side effects that may develop in the course of my treatment so that they may be addressed and do so early enough in session to allow for processing without going over my allotted time. Fresh Start Behavioral Health Inc recognizes and affirms a person's right to refuse or withdraw consent for treatment. In this event, efforts to develop alternative approaches in collaboration with the person served will be made to ensure that the person receives needed services. If consent for treatment is still withdrawn or revoked, efforts will be made to ensure that the person understands the implications and consequences of not receiving treatment. I understand that all records and reports are considered confidential and will not be released to any individual or agency without my prior written authorization. However, information may be released without my prior authorization under the following circumstances: Upon receipt of a subpoena Duces Tecum.

1. In the event of a medical emergency.
2. If there is evidence to suggest that child abuse has occurred.
3. To validate an insurance claim and then only information sufficient to substantiate claim.
4. Release authorized in accordance with state and/or federal laws and regulations pertaining to professional standards review.
5. To qualified personnel for research, audit or program evaluation.
6. To comply with federal laws and regulations about a crime committed by a client, either at the program or against any person who works for the program or about any threat to commit such a crime.
7. In the event of communicated harm to self or others.
8. To my therapist's supervisor or in peer review with other agency clinicians who are also bound to protect client confidentiality.

Confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal Law and Regulations. Violation of this by a program is a crime. (See 42 U.S.C.

290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part b, paragraph 2.22, for Federal Regulations.)

Signature: _____ Date: _____

Relationship: Self: _____ Parent:_____Guardian:_____

Staff: _____ Date:_____

FINANCIAL POLICY AND AGREEMENT
for Mental Health and AOD Services

We are committed to providing you with the best possible care and would be happy to discuss our financial fees with you at any time.

<u>*CO PAYMENTS OR FULL PAYMENT IF DEDUCTIBLE APPLIES, ARE DUE AT TIME OF SERVICE *WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER</u>

Insurance: If you have insurance, we will help you receive maximum benefits. You are responsible for providing all insurance coverage information and establishing the primary and secondary coverage at the time of service. We will accept and file your insurance if we are a provider on your plan. Your insurance coverage is a contract between you and your insurance carrier. All co pays must be paid at the time of service. If your insurance requires a deductible before they will pay, you will be responsible for your deductible until it is paid. Once we file your insurance, if payment is not received within 60 days, you will need to submit the payment for the balance due or make payment arrangements with our office.
As a Fresh Start Behavioral Health Inc. client, the following fees apply for services received.

Services	Mental Health Fees	AOD Fees	Self-Pay Fees
Intake with Therapist (1 hour)	$111.11	$111.11	
Per Session with Therapist (1 hour)	$102.31	$102.31	
INTAKE with doctor (1-hour)	$236.92	$236.92	
PER SESSION with doctor (20-30 minutes)	$165.15	$165.15	
HEALTH HISTORY with nurse (1 hour)	$127.68	$127.68	
PER SESSION for Group (1-hour)	$21.63	$21.63	
PER SESSION for Case Management (1- hour)	N/A	$78.16	
Urine Drug Screen	N/A	$14.48	
CPST Individual (1-hour)	$78.16	N/A	
CPST Group (1-hour)	$35.96	N/A	
INTENSIVE OUTPATIENT (IOP) (Day)	N/A	$149.88	
CRISIS INTERVENTION (1- hour)	$112.27	$112.27	

***Fees subject to change without notice**.

Missed Appointments:

*If you miss or cancel (without 24 hours' notice) three consecutive appointments your case will be reviewed by your treatment team for closure.

*If you miss or cancel (without 24 hours' notice) three appointments within a calendar year your case will be reviewed by your treatment team for closure.

*Referrals will be made for discharge planning.

*You may reapply for reinstatement, but you will have to go through the intake process again and your commitment to treatment will be reassessed along with other established criteria to determine if you can resume services at Fresh Start Behavioral Health Inc. I understand that all payments are made at the time of service. I also understand that my services may be reduced and/or interrupted if I am unable to pay.

I understand that only payment arrangements that are approved by the Executive Director/CEO, or her designee, are valid. I understand I can contact the Executive Director/CEO.

Print Client Name: _____ Date:_____

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

INTAKE QUESTIONNAIRE

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

Date of Birth: _____ Age (at time of interview): _____ SS No: _____

City/State of Birth: _____ County of Birth:_____

Insurance Information

Primary Insurance_____ Group #_____ Policy #: _____

Secondary Insurance_____ Group #_____ Policy #: _____

Driver's License or State ID City/State: _____

License or ID #: _____

Vehicle: None _____ Year:_____ Make_____ Model_____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed
___ Married, Living Separately

If married, how long have you been together?_____ Married? _____

If single, do you currently have a significant relationship? ___ No ___ Yes

Please explain: _____

_____

_____

Are you a US citizen? ___ No ___ Yes

Ethnicity (Circle all that apply):

American Indian Native Hawaiian/Other Pacific Islander
Black/African American
Hispanic Asian
White Other: _____

Primary Language: English Other: _____

Other secondary language: _____

Proficient in English? ___ No ___ Yes

Veteran: ____No _____ Yes If yes, date of discharge: _____

Level of Education Last Grade Completed: _____GED

Some College

Technical training in:_____College Degree_____ Master's Degree_____

Last Address _____

Have you stayed in a shelter before? _____No _____Yes If yes, when? _____

Which one?

_____

Where did you sleep the night before you entered Fresh Start? Be specific. _____

_____

_____

_____

Have you been incarcerated recently, where did you sleep before incarceration? Be specific. ____

_____

_____

Why did you leave your last housing situation? Circle all that apply:

Rent problems	Evicted for reason other than rent	Fire
Conflict with family/friends	Overcrowding	Went into hospital
Domestic Violence	Went to prison or jail for _____	

What caused you to be homeless? _____

_____

_____

Provide housing and/or shelter history for the last three years:

Location/County (include places not meant for human habitation)	Approximate Dates	Lease Holder? Yes/No	If not lease holder, name of and relationship to primary tenant.

Zip code of last permanent address: _____

Identify a family member in the area:

Name: _____ Relationship:_____

Address: _____

Reason why you cannot stay with this family member: _____

_____

Identify a friend in the area:

Name: _____

Address: _____

Reason why you cannot stay with this friend: _____

_____

How much was your income in the last 30 days?
(Review income information. If zero, client must complete income self-declaration form.) $

_____

Amount of money in: Checking: $_____ Does not have one

Savings: $_____ Does not have one

What is your current source of income? Fill in amount for each:

Unemployment	$_____	SSI	$_____
SSD	$_____	TANF (welfare)	$_____
Short-term Disability	$_____	Social Security	$_____
Child Support	$_____	Veterans Benefits	$_____
Other	$_____	Other:	$_____

Do you have a payee? _____ Yes _____No Do you receive food stamps? _____No ____ Yes

---

Do you have medical coverage? ____ No ___ Yes

If yes, what kind? _____

Do you have any medical needs right now? _____ No _____Yes

If yes, please explain: _____

_____

How long have you been sober? _____

_____

Have you ever been hospitalized for mental illness? ___ No ___ Yes If yes, how many times, where and for how long _____

_____

_____

Have you been or are you currently on medication(s) for mental health issues? ___ No ___ Yes If yes, what meds and who prescribed them? _____

_____

_____

Are you currently linked with a community mental health agency? ___ No ___ Yes If yes, which agency and who is your case manager and/or therapist? _____

_____

_____

Have you ever been linked with an MRDD provider? ___ No ___ Yes If yes, where and when:

_____

_____

_____

Were you enrolled in any special classes during school? ___ No ___ Yes If yes, where, when and what classes? _____

_____

_____

_____

_____

List all medications currently prescribed:

Medication	Dose	Frequency	Prescribed By

Do you know why you are taking these medications? No _____Yes

Do you have any side effects from any of these medications? _____No _____ Yes

If yes, please explain: _____

_____

_____

Do you take your medications as prescribed (without prompting)? _____No _____Yes

Are you a registered sex offender? _____ No _____Yes

Are you currently on probation or parole? ___ No ___ Yes

If yes, for what? _____

Probation/Parole Officer: _____

Contact Information: _____

Are you currently involved with Children Services? ___ No __ Yes

If yes, CSB Caseworker: _____

Contact Information: _____

Do you have a current driver's license? ____ No _____ Yes _____ Suspended

If suspended, for what? _____

Do you owe a reinstatement fee? _____No _____ Yes

If yes, how much? $_____

Previous employment (begin with most recent employer):

Full-time or part-time (circle one) Employer: _____

Dates of Employment: _____

Job Title: _____

Reason for Leaving_____

Full-time or part-time (circle one) Employer: _____

Dates of Employment: _____

Job Title: _____

Reason for Leaving:_____

Full-time or part-time (circle one) Employer: _____

Dates of Employment: _____

Job Title: _____

Reason for Leaving:_____

Number of adult arrests: _____

Number of charges: _____

Number of convictions: _____

Do you feel that you might benefit from any of the following?

Academic Training	Yes	No
Vocational Training	Yes	No
Employment Assistance	Yes	No
Secure Suitable Housing	Yes	No
Alcohol/Drug Counseling	Yes	No
Emotional/Psychological Counseling	Yes	No

Sexual Behavior Counseling	Yes	No
Anger/Rage Management	Yes	No
Family/Marriage Counseling	Yes	No

What are your treatment goals? _____

_____

_____

_____

What issues would you like to work on while in the Transitional Housing Program? (If applying for transitional housing with Fresh Start Behavioral Health.)

_____
_____
_____
_____
_____

Screener's Comments (including recommendations):

_____
_____
_____
_____
_____
_____
_____
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_____ _____

Screener's Signature/Credentials Date

Telehealth Policy and Consent

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using the telephone, interactive audio, video or data communications.

Telehealth seeks to improve a client's health by permitting two-way, real time interactive communication between the client and the practitioner at different sites, while assuring client access to care. It has allowed individuals who are unable to come into the office or who may not have local access to use electronic means to receive services

FSBHI ELIGIBILITY/REQUIREMENTS

- Staff/Practitioner must be licensed to practice in the State of Ohio. Non licensed professionals can provide telehealth services but this must be discussed with FSBHI supervisor prior to doing telehealth.
- Staff/Practitioner will use interactive conferencing with real-time audio/visual communications to allow for accurate behavioral health/medical services.
- Staff/Practitioner will ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the current COVID-19 regulations regarding the privacy and security of protected health information.
- Staff/Practitioner will use secure telemedicine software approved by FSBHI. Examples of such software are HIPAA compliant software such as Zoom and Doximity app and Skype. These are related to the good faith provision of telehealth. Practitioners are to notify patients/clients that these third-party applications potentially introduce privacy risks and providers should enable all available encryption and privacy modes when using these applications.
- Facebook Live, Twitch, Tik Tok and similar video communications applications that are public facing CANNOT be used in the provision of telehealth.
- Services are to be provided in office or non-public area. The FSBHI office will remain open unless otherwise authorized by state or local officials. To preserve privacy, both parties must be in a private/non-public place when doing telehealth. The provider will verify that the client is in a non-public place during telehealth.
- Client must have an active full time or part time contract with FSBHI, currently providing services to patients.

CLIENT ELIGIBILITY/REQUIREMENTS

- All clients must have an assessment and valid treatment plan
- All clients must give signed consent for telehealth and this is to be documented. All clients are encouraged to sign a Telehealth Consent form as soon as possible. These can be validated/initialed by staff when clients cannot come into the office.
- If doing telehealth by phone (cellular or landline, FSBHI must have that phone number on file.

DESCRIPTION AND DOCUMENTATION OF SERVICES

- All sessions MUST be on the EHR schedule prior to the Telehealth Session
- Sessions can be done via telephone, interactive audio, video or data communications which can be downloaded on smartphones, tablets and computers.
- Providers or Clients may come to the FSBHI office to do telehealth. Computers are available for clients or practitioners to use at the FSBHI office if they do not have the technology/equipment to do telehealth at home or in a private area.
- During counseling sessions, if video is being used, both parties must be present and visible to each other.
- Prior to telehealth session, practitioner will need to receive verbal clarification from client that they are in a private area while receiving services. This will further confirm the client's privacy and allow the provider to 'adjust' their encounter if the client is not alone e.g., children in the same room.
- Telehealth sessions should be in the same time frame as if you were doing face to face sessions. There should be no change in length of service unless clinically indicated. However, if the time is SHORTENED, it is to be documented in the START TIME, END TIME and DURATION sections of the note.

I hereby consent to have treatment services provided via telemedicine services described above. I understand that this includes telephone calls, as well as, audio visual media, to include Doximity, Zoom, and other HIPPA compliance applications. This does not include Facebook, WhatsApp., or other social media applications.

I understand that there are inherent security risks associated with telemedicine. I accept these risks

Printed Name:_____ Signature:_____

Date Signed:_____

FSBHI representative:_____

Wellness Screening & Treatment Consent
Covid

To our Fresh Start Patients:

We are very much looking forward to continuing care in the safest possible way for both patients and staff. Part of that initiative includes this Wellness Screening and Treatment Consent that we request is returned every Monday. If you have been exposed to a communicable disease prior to your appointment, you may spread the disease to the staff and to other patients in the practice. Therefore, prior to each appointment, we require you to answer the following questions: Have you, your child or others accompanying you to today's appointment been tested positive for or been diagnosed as having Covid-19?

Yes_____ If so when? _____ No_____

Do you, your child, or others accompanying you to today's appointment have:

A Fever?	Yes	_____	No	_____
A Cough?	Yes	_____	No	_____
Shortness of Breath and/Trouble Breathing?	Yes	_____	No	_____
Persistent pain, pressure or Tightness in Chest?	Yes	_____	No	_____
Diarrhea?	Yes	_____	No	_____

If the answer is yes to any of the previous questions, I understand I will be asked to reschedule today's appointment. Please be assured that our staff has always met or exceeded the requirements set forth for sterilization & infection control from the CDC & OSHA and will continue to do so. However, it is possible to contract Covid-19 infection (or any other communicable disease) in any public space. Social distancing nationwide has reduced the transmission of Covid-19; however, it is not possible to provide treatment with social distancing between the patient and staff and sometimes, other patients. Exposure to communicable diseases is unlikely but possible. You understand and accept the potential risks involved & give consent for treatment to be provided by Fresh Start Behavioral Health.

Consent for Patient Email and Text Messaging

I confirm that I wish to communicate with Fresh Start Behavioral Health, if given the option, by email/text and have read and understand the following information:

Risks of using Email/Text Messaging:

Transmitting patient information by email and/or text messaging has a number of risks that clients should consider prior to the use of email and/or text messaging. These include, but are not limited to, the following risks:

1. Email and text senders can easily misaddress an email or text and send information to an undesired recipient.
2. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
3. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Email and texts can be used as evidence in court.
6. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and text messages:

Providers at Fresh Start Behavioral Health cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct.

Patients/parents/legal guardians must acknowledge and consent to the following conditions:

1. It is my request to use email/text.
2. Any decisions to use email/text communication will be discussed in staff supervision and an entry will be made into my electronic medical records.
3. I understand that email and text are not a secure way to communication, and that this communication is not protected and the confidentiality of this communication cannot be guaranteed.
4. No emails/texts with urgent messages will be sent. Email and texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
5. When sending emails/texts I will not identify anyone by name.
6. All communications will be documented in my medical record.
7. It is my responsibility to inform the providers and Edelweiss Behavioral Health of any changes in email addresses, mobile numbers or lost mobiles as soon as possible.
8. Any decision by either me or the provider to stop the use of email/text will be respected. Any resumption will therefore require a new consent form.
9. Confidentiality will be respected by providers at all times.

10. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
11. All emails will be entered into the patient's electronic medical record; texts may be filed as well.
12. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
13. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
14. It is the patient/parent/legal guardian's responsibility to follow up and/or schedule an appointment if warranted. I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the use of text messaging and emails. I understand the risks associated with the communication of email and/or text messaging between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text.

. _____ _____

Printed name of client ages 18 years or older or legal representative Date

. _____ _____

Signature of client ages 18 years or older or legal representative Date

. _____ _____

Provider name (printed) and signature Date

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 CFR Parts 10 and 164)

The Health Insurance Portability and Accountability Act (HIPAA establishes patient rights and protections associated with the use of protected health information. HIPAA provides patient protections related to the electronic transmission of date ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health records.

The Patient Notification of Privacy Right informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy of your mental health records If you have questions regarding matters discussed in this Patient notification, please do not hesitate to ask.

I. Preamble

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA clearly defines what kind of information is to be included in your "designated medical record" or "case record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers. HIPAA provides privacy protections about your personal health information, which is called "protected health information ({HI)" which could personally identify you. PHI consists of three (3) components: treatment, payment and health care operations.

Treatment refers to activities/sessions I provide, coordinate or manage your mental health care service or other services related to your health care. Examples include a counseling session or communication with your primary care physician about your medication or overall medical condition. Payment is when Fresh Start Behavioral Health Inc., obtains reimbursement for your mental health care or other services related to your health care.

Health care operations are activities related to my performance such as quality assurance. The use of your protected health information refers to activities my agency conducts for scheduling appointments, keeping records, and other tasks related to your care. Disclosures refer to activities you authorize such as the sending of your protected health information to other parties (i.e., your insurance company).

II. Uses and Disclosures of Protected Health Information requiring Authorization

If you request Fresh Start Behavioral Health to send any of your protected health information of any sort to anyone outside this office, you must first sign a specific authorization to release information to this outside part. A copy of that authorization form is available on the website and upon request. In

recognition of the importance of the confidentiality of conversations between therapist and patients in treatment settings, HIPAA permits keeping “psychotherapy notes” separate from the overall “designated medical record”. “Psychotherapy notes" are the therapist’s notes “recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, joint family counseling session and that are separated from the rest of the individual’s medical record.” “Psychotherapy notes” are [private and contain information about you and your treatment.

III. Uses and Disclosures Not Requiring Consent or Authorization

By law, protected health information may be released without your consent or authorization under the following conditions.

- Suspected or known child abuse or neglect
- Suspected or known sexual abuse of a child
- Adult and Domestic abuse
- Judicial or administrative proceedings (i.e., you are ordered here by the court.)
- Serious threat to health or safety (i.e., “Duty to Warn” and Threat to National Security)

V. Patient’s rights and Our Duties

- The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to but if I do, such restrictions shall apply unless our agreement is changed in wiring
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want forms mailed to your home address so I will send them to another location of your choosing.
- The right to inspect and copy your protected health information is maintained in the record.
- The right to insert an amendment in your protected health information, although the therapist may deny an improper request and/or respond to any amendment(s) you make to your record of care.
- The right to an accounting of non-authorized disclosures of your protected health information.
- The right to a paper copy of notices/information from FSBHI, even if you have previously requested electronic transmission of notices/information
- The right to revoke our authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask for further assistance on these matters. FSBHI is required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. FSBHI reserves the right to change its privacy policies and practices as needed with the current designated practices being applicable unless you receive a revision of these policies when you come for future appointment(s). Our duties in these matters include maintaining the privacy of your protected health information, to provide you with the notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of the notice unless it is changed and you are so notified.

VI. Complaints

The right to have oral or written instructions for filing a grievance. The right to file a grievance is not time limited. If you need assistance in filing a grievance or want further information, please contact.
Ohio Department of Mental Health
Eight Floor, Rhodes State Office Tower
30 East Broad Street
Columbus, Ohio 43266-0414
(330) 264-2527

OR

Mental Health and recovery Services Board of Stark County
121 Cleveland Avenue SW
Canton, Ohio 44702
(330) 455-7424

Please print, sign, and date this form below to acknowledge that you have familiarized yourself with Confidentiality/HIPAA practices.

I, _____, (Patient), have either downloaded or have been provided a copy of The Patient Notification of Privacy Rights.

My signature below indicates that I had the opportunity to review this document prior to signing it.

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Release of Information

HIPAA Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. 42 CFR part 2 prohibits unauthorized disclosure of these records.

Authorization:

Print Name of Patient:	
Date of Birth:	SSN:

From:

I authorize the following using or disclosing party:

FRESH START BEHAVIORAL HEALTH INC.
1909 W Alex Drive
West Carrollton, Ohio 45449
937-247-9102
FAX: 937-388-8569

The above party may disclose this health information to the following recipient: Name (or title) and organization:

TO:

Name of Recipient

Address:

City: Fax: Email:

to use or disclose the following health information

At my request my complete health record.
Discharge Summary
History and physical exam
Consultation Reports
Reports of Operations
Imaging reports
Diagnostic cardiology reports
Laboratory Reports (Collect Test and Report Back Anything in reference to Prescriptions and Medications

The purpose of this authorization is (check all that apply):

Continuity of Care
Healthcare
Employment
Payment/Insurance
Other:

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in

the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked. It will expire on the date or completion of the event stated below.

Release information from Date _____ to Date _____

If no date or event is specified below, this authorization will expire 365 days from the date of discharge

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

The information contained herein may not be redisclosed without my written permission or written consent.

I understand that enrollment, treatment, payment or eligibility is not conditioned on my authorization for the release of information.

“42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that I will be responsible for full payment for all services provided.

FSBHI will not condition treatment, payment, enrollment, or eligibility on client’s authorization for the release of information

Signature of Patient _____ Time & Date _____

Release of Information - Labs

HIPAA Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. 42 CFR part 2 prohibits unauthorized disclosure of these records.

Authorization:

Print Name of Patient:	
Date of Birth:	SSN:

From:

I authorize the following using or disclosing party:

FRESH START BEHAVIORAL HEALTH INC.
1909 W Alex Drive
West Carrollton, Ohio 45449
937-247-9102
FAX: 937-388-8569

The above party may disclose this health information to the following recipient: Name (or title) and organization:

TO:

Radeas Lab
907 Gateway Commons Circle
West Forest, North Carolina, 27587
919-263-1150

to use or disclose the following health information

At my request my complete health record.
Discharge Summary
History and physical exam
Consultation Reports
Reports of Operations
Imaging reports
Diagnostic cardiology reports
Laboratory Reports (Collect Test and Report Back Anything in reference to Prescriptions and Medications

The purpose of this authorization is (check all that apply):

Continuity of Care
Healthcare
Employment
Payment/Insurance
Other: _____

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked. It will expire on the date or completion of the event stated below.

Release information from Date _____ to Date _____

If no date or event is specified below, this authorization will expire 365 days from the date of discharge

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

The information contained herein may not be redisclosed without my written permission or written consent.

I understand that enrollment, treatment, payment or eligibility is not conditioned on my authorization for the release of information.

“42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that I will be responsible for full payment for all services provided.

FSBHI will not condition treatment, payment, enrollment, or eligibility on client’s authorization for the release of information

Signature of Patient _____ Time & Date _____

Release of Information - Pharmacy

HIPAA Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. 42 CFR part 2 prohibits unauthorized disclosure of these records.

Authorization:

Print Name of Patient:	
Date of Birth:	SSN:

From:

I authorize the following using or disclosing party:

FRESH START BEHAVIORAL HEALTH INC.
1909 W Alex Drive
West Carrollton, Ohio 45449
937-247-9102
FAX: 937-388-8569

The above party may disclose this health information to the following recipient: Name (or title) and organization:

To Your Pharmacy:

Name of Recipient		
Address:		
City:	Fax:	Email:

to use or disclose the following health information

At my request my complete health record.
Discharge Summary
History and physical exam
Consultation Reports
Reports of Operations
Imaging reports
Diagnostic cardiology reports
Laboratory Reports (Collect Test and Report Back Anything in reference to Prescriptions and Medications

The purpose of this authorization is (check all that apply):

Continuity of Care
Healthcare
Employment
Payment/Insurance
Other: _____

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked. It will expire on the date or completion of the event stated below.

Release information from Date _____ to Date _____

If no date or event is specified below, this authorization will expire 365 days from the date of discharge

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

The information contained herein may not be redisclosed without my written permission or written consent.

I understand that enrollment, treatment, payment or eligibility is not conditioned on my authorization for the release of information.

“42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that I will be responsible for full payment for all services provided.

FSBHI will not condition treatment, payment, enrollment, or eligibility on client’s authorization for the release of information

Signature of Patient _____ Time & Date _____

Release of Information - PO

HIPAA Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. 42 CFR part 2 prohibits unauthorized disclosure of these records.

Authorization:

Print Name of Patient:	
Date of Birth:	SSN:

From:

I authorize the following using or disclosing party:

FRESH START BEHAVIORAL HEALTH INC.
1909 W Alex Drive
West Carrollton, Ohio 45449
937-247-9102
FAX: 937-388-8569

The above party may disclose this health information to the following recipient: Name (or title) and organization:

To Your PO:

Name of Recipient		
Address:		
City:	Fax:	Email:

to use or disclose the following health information

At my request my complete health record.
Discharge Summary
History and physical exam
Consultation Reports
Reports of Operations
Imaging reports
Diagnostic cardiology reports
Laboratory Reports (Collect Test and Report Back Anything in reference to Prescriptions and Medications

The purpose of this authorization is (check all that apply):

Continuity of Care
Healthcare
Employment
Payment/Insurance
Other: _____

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked. It will expire on the date or completion of the event stated below.

Release information from Date _____ to Date _____

If no date or event is specified below, this authorization will expire 365 days from the date of discharge

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

The information contained herein may not be redisclosed without my written permission or written consent.

I understand that enrollment, treatment, payment or eligibility is not conditioned on my authorization for the release of information.

“42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that I will be responsible for full payment for all services provided.

FSBHI will not condition treatment, payment, enrollment, or eligibility on client’s authorization for the release of information

Signature of Patient _____ Time & Date _____

Release of Information

HIPAA Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. 42 CFR part 2 prohibits unauthorized disclosure of these records.

Authorization:

Print Name of Patient:	
Date of Birth:	SSN:

I authorize the following using or disclosing party:

From:

Name of Recipient		
Address:		
City:	Fax:	Email:

The above party may disclose this health information to the following recipient: Name (or title) and organization:

TO:

FRESH START BEHAVIORAL HEALTH INC.
1909 W Alex Drive
West Carrollton, Ohio 45449
937-247-9102
FAX: 937-388-8569

to use or disclose the following health information

At my request my complete health record.
Discharge Summary
History and physical exam
Consultation Reports
Reports of Operations
Imaging reports
Diagnostic cardiology reports
Laboratory Reports (Collect Test and Report Back Anything in reference to Prescriptions and Medications

The purpose of this authorization is (check all that apply):

Continuity of Care
Healthcare
Employment
Payment/Insurance
Other: _____

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in

the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked. It will expire on the date or completion of the event stated below.

Release information from Date _____ to Date _____

If no date or event is specified below, this authorization will expire 365 days from the date of discharge

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

The information contained herein may not be redisclosed without my written permission or written consent.

I understand that enrollment, treatment, payment or eligibility is not conditioned on my authorization for the release of information.

“42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that I will be responsible for full payment for all services provided.

FSBHI will not condition treatment, payment, enrollment, or eligibility on client’s authorization for the release of information

Signature of Patient _____ Time & Date _____

Controlled Substances Agreement/Informed Consent

State and federal laws require strict monitoring of controlled substances through the Drug Enforcement Agency and State Medical and Pharmacy Boards of Ohio. You have agreed to receive controlled substance for the treatment of your condition. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/informed consent below. If you have any questions regarding this information or the office policy regarding the prescribing of all legally monitored medications, including controlled substances, please request clarification.

I, _____, understand that:

Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit.

I understand that the goal of using controlled substances is to improve my symptoms and increase me.

Functional level. If my symptoms do not significantly decrease and/or my function increase, the

Medication may be stopped. I agree to actively participate in all aspects of my treatment.

This medication will be strictly monitored and all of my medications should be filled at the same pharmacy. If I change the routine pharmacy I go to, I will inform the office staff.

The pharmacy selected is:

Pharmacy: _____ Phone: _____

In order to protect against inappropriate use of controlled substances, all patients being prescribed such medications will be required to adhere to the following:

1. *I will not call the office to have a prescription called in.* Any exceptions to this will be at the prescriber's discretion.
2. *I am responsible for making and keeping scheduled appointments.* Early refill requests will not be honored. A rare exception may be made at the discretion of your provider.
3. *I will take the controlled medication only as prescribed*. Any changes must first be discussed and agreed upon by the FSBH provider.
4. *Medications will not be replaced if they are lost or damaged*. If my medication has been stolen and I complete a police report regarding the theft, a rare exception may be made at the discretion of your provider. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
5. *I agree that only an FSBH provider will prescribe the controlled medication*. I will not obtain or use controlled substances from a source other than FSBH unless agreed upon, such as from another specialist (for example pain management).
6. It is understood that Release of Information forms need to be signed to let the FSBH prescriber speak to other providers.
7. I will instruct any other physician to confer with FSBH for any changes or need for additional controlled substances. If it is brought to the attention of FSBH that other providers are prescribing medication for me without first conferring with FSBH, FSBH may discontinue prescribing medication.

8. I will inform my FSBH provider of any changes in my medical conditions, any changes in any prescriptions and/or over the counter medication that I take and of any adverse effects that I may experience from any of the medications that I take.
9. I agree to tell my FSBH provider my complete and honest personal drug/medication usage and history.
10. *I will not use any illegal "street drugs" while receiving controlled substances from FSBH, nor accept any controlled medication prescribed to another individual*.
11. Routine blood work and random drug screens may be a part of my treatment plan. I agree to have them done on the day the physician requests it.
12. *While on controlled medication, counseling on a regular basis may be required, as determined by a prescriber and other healthcare providers*. One of the goals of counseling would be improved ability to cope with stress, so these medicines may no longer be medically necessary. It is understood that the failure to attend required counseling may result in termination of controlled substance.
13. **I know that controlled substances may be stopped if any of the following occur:**
    1. *I trade, sell or misuse the medication.*
    2. *The clinic finds that I have broken any part of this agreement.*
    3. *I do not immediately submit a blood or urine test when asked.*
    4. *My blood or urine test shows the inappropriate presence of: medications that the staff are not aware of, incorrect dosages of medications, the presence of illegal drugs, or does not show medication that I am receiving a prescription for.*
    5. *If I am not taking my medications as instructed I will inform my physician.*
    6. *If I get unapproved controlled substances from sources other than FSBH (exceptions may occur and I will inform my physician of any other prescriptions written by another physician).*
    7. *If a member of the medical staff of FSBH feels that it is in my best interests that*
    8. *controlled substance treatment is stopped.*
    9. *Any aggressive behavior toward physician or staff.*
    10. *I consistently miss scheduled appointments.*

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing by FSBH. I have read this agreement/informed consent in full and understand all of this agreement/informed consent. By signing this agreement/consent. I affirm that I have read, understand, and accept all of the terms of this agreement/informed consent.

Patient/Guardian Signature: _____ Date:_____

Patient Date of Birth: _____

Clinic Witness: _____ Date:_____

Please Remove this Form and read the Client Handbook then sign and turn in. You have 2 weeks from the date of intake.

Receipt of And Understanding of Information Contained in Client Handbook.

I have read and understand all of the information referenced above or someone has read and explained all of it to me. I am aware and informed of the nature and purpose of the services, possible alternative options and approximate length of care. I understand that, while there are clear benefits to receiving services, desired outcomes are not guaranteed. I have been provided the opportunity to ask questions throughout this process. I agree to follow all of the rules described and am aware of my rights and responsibilities in the program. I understand that I can revoke my agreement with any and all of the conditions listed in this document, but understand that it may result in being transferred or referred to another facility.

Client Signature: _____ Date:_____

Printed Name:_____

I have reviewed the contents of this booklet with the individual seeking services and have offered opportunities for clarification and explanation of contents.

Staff Signature:_____Date:_____

Printed Name: _____