Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

Dear Patient,

Thank you for choosing Hope Revealed Behavioral Health Center, Inc. for your care.

We have a detailed intake process that is designed to improve efficiency and provide the best service possible. In order to set up an appointment and receive an appropriate evaluation, we ask that you carefully fill out all of the enclosed forms as completely as possible and return them in person, via email, fax or US mail to the address provided below. Once we receive your packet, the information will be reviewed and the appropriate clinician appointed. You will be contacted by one of our staff for appointment options.

Enclosed are the following:

- Patient Information Sheet
- Adult History Questionnaire
- Screening
- Release of Information
- Consent for Treatment
- Patient Rights

Please include when returning:

- A Copy of the front and back of your insurance card(s)
- A copy of your Advance Directive, if you chose to use one.
- A copy of your Driver's license or State ID.

Methods for returning your completed packet, (or personal delivery):

Fax: 405-481-7219

Email: whitneyre86@yahoo.com

US Mail: 1605 N. Harrison St.
Shawnee, OK 74804

Again, thank you for choosing Hope Revealed Behavioral Health Center, Inc. We are honored to serve you.

Sincerely,

Serena Ward, M.Ed., LPC
Executive Director
Oklahoma LPC #4722

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

INFORMATION ALL PATIENTS SHOULD KNOW ABOUT

BEHAVIORAL HEALTH INSURANCE COVERAGE

Hope Revealed Behavioral Health Center, Inc. provides in-network services for a variety of insurance providers. We also provide documentation of billing and services if you prefer out-of-network coverage, or choose to pay out of pocket. We are certified through ODMHSAS and also accept Medicaid/Soonercare.

Please note that behavioral/mental health coverage is frequently different from medical coverage. Also benefits allowed by your insurance provider are frequently subject to change beyond our control. We strongly encourage you to contact your insurance provider or benefits administrator to verify the specific behavioral/mental health services allowed by your insurance plan.

- **Soonercare/Medicaid Eligibility and preauthorization:** After you have provided a copy of your Soonercare card, we are able to gain preauthorization for you through ODMHSAS.

- **Verification of behavioral/mental health benefits and preauthorization for services (excluding Soonercare):** Please obtain information regarding your behavioral/mental health benefits and preauthorization before your first visit.

- **Co-payments:** Costs are often a percentage of the charges incurred instead of a fixed dollar amount. Information about co-payments for behavioral/mental health services is rarely listed on the insurance card and is obtained by calling the plan.

- **Deductibles:** Behavioral/mental health services are often separate and in addition to the medical deductible outlined by your insurance plan. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

- **Limits:** Frequently, behavioral/mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

Client's Name: _____

Identifier: _____

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Patient's Name (Last, First MI): _____

Patient's Date of Birth: ___ / ___ / ___ **Gender:** ___

RACE/ETHNICITY:

- ◯ American Indian/Alaska Native
- ◯ Asian Indian/Pakistani
- ◯ Asian: Chinese
- ◯ Hispanic/Latino
- ◯ Asian: Other (specifiy)
- ◯ Black/African American
- ◯ White/Caucasian
- ◯ Other _____

Mailing Address: _____ **City, State, ZIP:** _____

Home Telephone: _____ **Cell Phone Number:** _____

Email Address: _____

Preferred method of contact for appointment reminders and other electronically generated messages:

◯ **Voice** ◯ **Text** ◯ **Email**

REASON FOR SEEKING BEHAVIORAL HEALTH SERVICES (check all that apply)

- ☐ Anger Management
- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Autism
- ☐ Suicidal Ideation
- ☐ Obsessive Compulsive Disorder
- ☐ Impulse Control
- ☐ Homicidal Ideation
- ☐ Visual Hallucinations
- ☐ Audible Hallucinations
- ☐ Social Problems
- ☐ Problems with Relationships
- ☐ Other _____

WHO REFERRED YOU TO HOPE REVEALED BEHAVIORAL HEALTH CENTER, INC.?

- ◯ Primary Care Physician
- ◯ Friend/Family
- ◯ Employer
- ◯ Social Worker/Case Worker
- ◯ Emergency Room
- ◯ Psychiatric Hospital Discharge
- ◯ Lawyer/Court
- ◯ Self-referral
- ◯ Other _____

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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INSURANCE INFORMATION

Primary Insurance Company: _____ Group Name: _____

Policy/Identification Number: _____ Group Number: _____

Subscriber's/Policy Holder's Name: _____

Subscriber's/Policy Holder's Date of Birth: ____ / ____ / _____

Significant Other/Spouse Name: _____

☐ **CHECK THIS BOX IF ADDRESS IS SAME AS PATIENT**

Address: _____ City, State, ZIP: _____

Phone Number: _____ Date of Birth: ____ / ____ / _____

Profession and/or work activity: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Phone Number: _____

RELIGION

◯ Buddhist	◯ Christian Catholic	◯ Christian Protestant
◯ Hindu	◯ Jewish	◯ Muslim
◯ Other	◯ None	

FAMILY HISTORY

With whom do you live? _____

Were you adopted? ◯ **Yes** ◯ **No**

Describe childhood family experience:

☐ outstanding home environment	☐ witnessed physical/verbal/sexual abuse toward others
☐ normal home environment	☐ experienced physical/verbal/sexual abuse from others
☐ chaotic home environment	

Client's Name: _____

Identifier: _____

HOPE REVEALED

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Siblings:

	. Á Í Å	' ÅÎÄÅÒ	! ÇÅ	! ÃÔÉÖÅT) ÎÁÃÔÉÖÅ É Î ÙÏÕÒ ÌÉÆÅ	
ρ8				Active	Inactive
ς8				Active	Inactive
σ8				Active	Inactive
τ8				Active	Inactive
υ8				Active	Inactive

Are your parents divorced? Yes No

If yes, how old were you? _____

Describe parents:

	Father	Mother
Full Name		
Occupation		
Education		
General Health		

Children:

	Name	' ÅÎÄÅÒ	! ÇÅ	! ÃÔÉÖÅT) ÎÁÃÔÉÖÅ É Î ÙÏÕÒ ÌÉÆÅ	
ρ8				Active	Inactive
ς8				Active	Inactive
σ8				Active	Inactive
τ8				Active	Inactive
υ8				Active	Inactive

How satisfied are you with your current family life?

6ÅÒÙ 5 ÎÓÁÔÉÓÆÉÅÄ 5 ÎÚÓÁÔÉÓÆÉÅÄ 3ÁÔÉÓÆÉÅÄ 6ÅÒÙ 3ÁÔÉÓÆÉÅÄ

Are childhood events contributing to current problems? Yes No

Current Marital Status:

3É ÎÇÌÅ - ÁÒÒÉÅÄ $ÉÖÏÒÃÅÄ 7 ÉÄÏ × ÅÄ 3ÅÐÁÒÁÔÅÄ

Number of Years Married: _____ **Total Number of Marriages:** _____

Client's Name: _____

Identifier: _____

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Present during childhood:

	Present entire childhood	Not Present part of childhood childhood at all	Not Present at all
mother	○	○	○
father	○	○	○
stepmother	○	○	○
stepfather	○	○	○
brother(s)	○	○	○
sister(s)	○	○	○
other	○	○	○

Parents' current marital status:

- ☐ married to each other
- ☐ separated for years
- ☐ divorced for years
- ☐ mother remarried ____ times
- ☐ father remarried ____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for ____ years
- ☐ father deceased for ____ years
- ☐ age of patient at mother's death
- ☐ age of patient at father's death

MEDICAL HISTORY

Primary Care Physician _____

PCP Phone Number _____

Do you have any allergies? (environmental, food, medication)? ○ **Yes** ○ **No**

1. _____
2. _____
3. _____
4. _____
5. _____

Do you see a physician for any on-going reason? ○ **Yes** ○ **No**

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS

Please list any medications and dosages you are currently taking (please include over the counter medications, herbals and any nutritional supplements).

1. _____
2. _____
3. _____
4. _____
5. _____

Client's Name: _____

Identifier: _____

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Check all that apply:	Childhood	Adult	Recently
Serious Illnesses	☐	☐	☐
Serious Injuries	☐	☐	☐
Serious Head trauma	☐	☐	☐

Nutrition: Do you purge, restrict, or overeat? ◯ Yes ◯ No

Have you had any difficulties or concerns related to food intake? ◯ Yes ◯ No

What do you consider to be the top three stresses in your life?

1. _____

2. _____

3. _____

Mood (past 1-2 weeks)**:**

☐ Calm ☐ Happy ☐ Sad ☐ Anxious

☐ Angry ☐ Frustrated ☐ Worried ☐ Hopeless

☐ Helpless ☐ Other _____

Behavioral Symptoms (problems experienced within the previous two months)**:**

☐ Sleep ☐ Enjoying Life Poor ☐ Loss of Sex Drive ☐ Periods of Very Low Energy

☐ Guilt ☐ Judgment ☐ Racing Thoughts ☐ Periods of Very High Energy

☐ Motivation ☐ Impulsivenss ☐ Appetite Change ☐ Strange Thoughts or Behavior

☐ Fatigue ☐ Can't Stop Talking

Mental Health History:

1. Have you been in counseling or mental health treatment before? ◯ Yes ◯ No
(i.e. Counselor, Psychiatrist, Psychologist, Marriage/Family Counselor)

2. Have you ever been hospitalized for mental or emotional problems? ◯ Yes ◯ No

3. Has anyone in your family had mental or emotional problems (e.g. nervous breakdown, depression, suicide, mania, drug or alcohol problems, etc.) ◯ Yes ◯ No

4. Have you ever been referred to Social Services? ◯ Yes ◯ No

Client's Name: _____

Identifier: _____

HOPE REVEALED

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CURRENT SYMPTOM CHECKLIST

(Rate intensity of symptoms currently present)

None = This symptom not present at this time.

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning.

Moderate = Significant impact on quality of life and/or day-to-day functioning.

Severe = Profound impact on quality of life and/or day-to-day functioning.

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	○	○	○	○	mood swings	○	○	○	○
bingeing/purging	○	○	○	○	aggressive behaviors	○	○	○	○
guilt	○	○	○	○	emotional trauma victim	○	○	○	○
appetite disturbance	○	○	○	○	agitation	○	○	○	○
laxative/diuretic abuse	○	○	○	○	conduct problems	○	○	○	○
elevated mood	○	○	○	○	physical trauma victim	○	○	○	○
sleep disturbance	○	○	○	○	emotionality	○	○	○	○
anorexia	○	○	○	○	oppositional behavior	○	○	○	○
hyperactivity	○	○	○	○	sexual trauma victim	○	○	○	○
elimination disturbance	○	○	○	○	irritability	○	○	○	○
paranoid ideation	○	○	○	○	sexual dysfunction	○	○	○	○
headaches	○	○	○	○	cannot make decisions	○	○	○	○
fatigue/low energy	○	○	○	○	generalized anxiety	○	○	○	○
circumstantial symptoms	○	○	○	○	grief	○	○	○	○
physical complaints	○	○	○	○	physical trauma perpetrator	○	○	○	○
psychomotor retardation	○	○	○	○	panic attacks	○	○	○	○
loose associations	○	○	○	○	hopelessness	○	○	○	○
self-mutilation	○	○	○	○	sexual trauma perpetrator	○	○	○	○
poor concentration	○	○	○	○	phobias	○	○	○	○
delusions	○	○	○	○	social isolation	○	○	○	○
significant weight gain/loss	○	○	○	○	substance abuse	○	○	○	○
poor grooming	○	○	○	○	obsessions/compulsions	○	○	○	○
hallucinations	○	○	○	○	worthlessness	○	○	○	○
concomitant medical condition	○	○	○	○	other (specify)	○	○	○	○

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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RISK ASSESSMENT:

	Yes	No	Recently	Today
Been so distressed you seriously wished to end your life?	○	○	○	○
Have you had or do you have:				
a. A specific plan how you would kill yourself?	○	○	○	○
b. Access to weapons/means of hurting self?	○	○	○	○
c. Made a serious suicide attempt?	○	○	○	○
d. Purposely done something to hurt yourself?	○	○	○	○
e. Heard voices telling you to hurt yourself?	○	○	○	○
Had relatives who attempted or committed suicide?	○	○	○	○
Had thoughts of killing or seriously hurting someone?	○	○	○	○
Heard voices telling you to hurt others?	○	○	○	○
Hurt someone or destroyed property on purpose?	○	○	○	○
Slapped, kicked, punched someone with intent to harm?	○	○	○	○
Been arrested or detained for violent behavior?	○	○	○	○
Been to jail for any reason?	○	○	○	○
Been on probation for any reason?	○	○	○	○

Social Support:

How satisfied are you with the support you receive from you family/Friends?

○ Very Unsatisfied ○ Unsatisfied ○ Satisfied ○ Very Satisfied

Have your current difficulties affected your family/friends/coworkers? ○ Yes ○ No

Education History: Years of education completed? _____

Degree(s) _____

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Quality Of Life:

Are you satisfied with your quality of life?

○ Very Unsatisfied ○ Unsatisfied ○ Satisfied ○ Very Satisfied

What do you do for leisure? _____

Are you able to enjoy leisure/recreational activities? ○ Yes ○ No

If no, why? _____

Job History:

How many jobs: Have you held? _____ Been fired from? _____

How satisfied are you with your current occupation?

○ Very Unsatisfied ○ Unsatisfied ○ Satisfied ○ Very Satisfied

Do you have performance problems or difficulties with boss? ○ Yes ○ No

Alcohol Use:

Do or did you:	In the Past		Recently	
Regularly use alcohol (more than twice per month)?	○ Yes	○ No	○ Yes	○ No
Had trouble (legal, work, family) because of alcohol?	○ Yes	○ No	○ Yes	○ No
Felt you should cut down on your drinking?	○ Yes	○ No	○ Yes	○ No
Been annoyed by people criticizing your drinking?	○ Yes	○ No	○ Yes	○ No
Felt bad or guilty about your drinking?	○ Yes	○ No	○ Yes	○ No
Ever had a drink first thing in the morning?	○ Yes	○ No	○ Yes	○ No

Other Substance Use/Abuse:

Do or did you:	In the Past		Recently	
Use medications (other than over the counter) that were not prescribed to you?	○ Yes	○ No	○ Yes	○ No
Taken more than the recommended daily dose of an over the counter medication?	○ Yes	○ No	○ Yes	○ No
Taken more than the prescribed dose of your prescription medication?	○ Yes	○ No	○ Yes	○ No
Taken or used any illegal substance?	○ Yes	○ No	○ Yes	○ No
Used any product or other means to get "high"?	○ Yes	○ No	○ Yes	○ No

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Habits:	In the Past		Recently	
Do you smoke or chew tobacco regularly?	◯ Yes	◯ No	◯ Yes	◯ No
Do you have problems with gambling?	◯ Yes	◯ No	◯ Yes	◯ No
Do you have other potentially harmful habits you want to change?	◯ Yes	◯ No	◯ Yes	◯ No

If so, what? _____

How many caffeinated drinks do you have per day (coffee, tea, sodas)? _____

How often do you exercise per week? _____

Preferred Exercise: _____

GOALS FOR TREATMENT

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself?

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

ADULT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby consent to and authorize Hope Revealed Behavioral Health Center, Inc to:

○ Release to ○ Release from

Name: _____ Facility/Group Name: _____

Address: _____ City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

The following information:

☐ Psychological/Educational Assessments ☐ Legal/Court documents ☐ Psychiatric Records

☐ DHS/Case Worker Reports ☐ Medical related information ☐ School related information

☐ Other _____

I also understand that my insurer requires certain information regarding my treatment, I agree to have this information released as requested. I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to the 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 may include drug/alcohol abuse treatment records. This specific category of medical information/record is protected by Federal law, (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further releases unless further release is expressly permitted by the written authorization of the client or is permitted by Federal Law, (42CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol/drug abuse client. As a result, by signing below, I specifically authorize any such records in my health information to be released.

_____ Initial Here. I understand that if my records are released, I may be charged a $24.00 Records Request Fee, payable prior to the release of the requested records. Your health insurance coverage will not reimburse you for this charge.

Patient Signature _____ Date of Birth ___/___/___ Date _____

Name of Legal Advocate (if applicable) _____

Signature of Legal Advocate (if applicable) _____ Date _____

Witness _____ Date _____

Hope Revealed Behavioral Health Center, Inc.
1605 N. Harrison St.
Shawnee, OK 74804
405-481-7187; Fax 405-481-7219

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

ADULT CONSENT TO RECEIVE OUTPATIENT BEHAVIORAL HEALTH SERVICES

I , _____ , give consent to receive outpatient behavioral health services at Hope Revealed Behavioral Health Center, Inc. Outpatient behavioral health services include any or a combination of the following: evaluation, individual therapy, group therapy, family therapy, behavioral health rehabilitative services, (BHRS) and Case Management. I consent to participate in program activities directly associated with my behavioral health evaluation and treatment, and as appropriate, to involve my family members. I authorize Hope Revealed Behavioral Health Center, Inc. to review my medical record for teaching, quality and audit purposes. I understand that the personal information that I provide about myself and my family will remain confidential and any published data will keep the identity of myself and family confidential.

DISCONTINUATION OF TREATMENT POLICY

Please be aware that Hope Revealed Behavioral Health Center, Inc. may discontinue your treatment for any of the following reasons:

- Achievement of treatment goals.
- Failure to appear for two or more appointments within a three-month period.
- Not participating in treatment for a period of 90 consecutive days.

By signing below, you are giving consent for treatment with Hope Revealed Behavioral Health Center, Inc.

Printed Name of Legal Advocate (if applicable)	**Signature**	**Date**
Printed Name of Patient	**Signature**	**Date**
Signature of Witness (Clinician)		**Date**

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

ADULT PATIENT/CLIENT BILL OF RIGHTS

As a patient/client at Hope Revealed Behavioral Health Center, Inc. you have a right:

- To be treated with dignity and respect.
- To receive the most appropriate treatment regardless of age, gender, race, religion, sexual orientation, national origin or method of payment.
- To know what fees will be charged for your treatment in advance.
- To know the name and professional status of those persons providing your treatment.
- To participate in the development of a comprehensive Individual Treatment Plan and to receive treatment according to this treatment plan.
- To privacy and confidentiality concerning your treatment and your medical record. Information your record will be released only with your written permission. However, all Hope Revealed staff involved with your treatment will share information with one another.
- To be free from physical, mental and sexual abuse or harassment.
- To be free from intrusive research.
- To have your concerns addressed in a timely manner, generally at the point of service, without fear of retaliation.
- To file a confidential verbal or written grievance regarding your treatment. An impartial investigation will be initiated within 24 hours of receipt of complaint. All complaints will be resolved within 30 days of the date of the grievance. To file a grievance, you may:

  1. Start informally by contacting the staff member. If your claim is not resolved in five (5) business days, you may contact:

  2. Whitney Elliott, Coordinator and Local Grievance Advocate

     Hope Revealed Behavioral Health Center, Inc.

     1605 N. Harrison, St., Shawnee, OK 74804

     Office: 405-481-7187; Fax: 405-481-7218

- As a patient/client at Hope Revealed Behavioral Health Center, Inc., you have a responsibility:
- To keep your appointment or notify us of any changes as early as possible.
- To collaborate in the development of your Individualized Treatment Plan and work toward achievement of treatment goals.
- To be honest with staff by sharing anything that might impact your treatment.
- To pay your fees on time/or discuss with staff any related financial difficulties.
- To promptly provide information regarding changes in health insurance, address, phone number and/or email address.
- To let staff know if you are dissatisfied in any way with your treatment.
- To inform staff of your desire to terminate treatment, especially if you have achieved your treatment goals.

Printed Name of Treatment Advocate (If applicable)	**Signature**	**Date**
Printed Name of Patient	**Signature**	**Date**
Signature of Witness (Clinician)		**Date**

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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ADULT CONSENT, AUTHORIZATION AND ASSIGNMENT OF INSURANCE AGREEMENT

I, _____, hereby authorize Hope Revealed Behavioral Health Center, Inc. to apply benefits on my behalf for services rendered. I request that payments made directly to Hope Revealed Behavioral Health Inc. I affirm that the information regarding insurance coverage is rue and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to any insurance company. A copy of this consent, authorization and assignment agreement may be used in place of the original. This agreement will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not paid by my medical insurance. I agree to assume responsibility for all charges incurred, should collection of his balance become necessary, including court costs and attorney's fees. I also understand that I will be charged a $50 Returned Check Fee for any checks returned for non-payment from my bank. Additionally, I understand that I am financially responsible for all non-appointment services, such as report preparation, record requests and court custody testimony. Payment for services is expected at the time of my appointment. Questions or payment arrangements regarding medical insurance coverage, should be addressed prior to appointment by contacting Hope Revealed office at 405-481-7187.

Printed Name of Treatment Advocate (If applicable)	**Signature**	**Date**
Printed Name of Patient	**Signature**	**Date**

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

USER ELECTRONIC MAIL AUTHORIZATION FOR ELECTRONIC NOTIFICATIONS

Hope Revealed Behavioral Health Center, Inc. may use an electronic patient notification system. This system is used to notify you of your appointment date/times, appointment reminders, practice alerts, (e.g., rescheduled appointments, unscheduled office closures due to severe weather, illness, etc.).

The electronic notifications are sent via text message, email and voice messages. By signing below, you are giving consent for us to text message and/or email, or leave a voice message regarding your appointments or group related messages. This system will not be used for marketing.

_____ _____

Cell Number including Area Code **Email Address**

_____ _____ _____

Printed Name of Treatment Advocate **Signature** **Date**

(if applicable)

_____ _____ _____

Patient's Printed Name **Signature** **Date**

_____ _____

Signature of Witness (Clinician) **Date**

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

ACKNOWLEDGEMENT OF RECEIPT OF CONSUMER

HANDBOOK AND PRIVACY PRACTICES

I acknowledge that I have been provided the Hope Revealed Behavioral Health Center, Inc. Notice of Privacy Practices:

It tells me how Hope Revealed Behavioral Health Center, Inc. uses my health information for the purpose of my treatment, payment for treatment and Hope Revealed Behavioral Health Center, Inc. operations.

It explains in detail how and to whom Hope Revealed Behavioral Health Center, Inc. may share my health information with other than treatment, payment and health care operations.

It explains in detail why Hope Revealed Behavioral Health Center, Inc. may share my health information as required/permitted by law.

I acknowledge that I have been provided the Hope Revealed Behavioral Health Center, Inc. CONSUMER HANDBOOK.

Printed Name of Treatment Advocate (if applicable)	**Signature**	**Date**
Printed Name of Patient	**Signature**	**Date**
Signature of Witness (Clinician)		**Date**

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It is the policy of Hope Revealed Behavioral Health Center, Inc., in accordance with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), to keep your health and personal information confidential. We will only use or disclose your information for the following reasons:

- Treatment: We will share your health information with other health providers who are involved in your care, (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others.
- Payment: We may use and disclose PHI when it is needed to receive payment for services provided to you. For example, if you have Medicaid benefits, we will release the minimum information necessary for the Medicaid program to pay us.
- Health Care Operations: We will use and disclose PHI when it is needed to make sure we are providing you with good patient care. For instance, we may review your records in order to make certain quality service was given.

Other uses of disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part of your information.
- When ordered to do so by a valid court order.
- When cases of child abuse or neglect are investigated.
- When business associates of ODMHSAS, such as community, sign agreements to protect your privacy.
- For children under age three, the Sooner-Start program shares information with the State Department of Education.
- When required by state law.
- We can share your information with anyone as necessary, consistent with Oklahoma law and the ODMHSAS polices and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious imminent threat to the health and safety of a person or the public.
- In case of a severe disaster we can disclose your information.
- We can share your information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for your care, of your location, general condition or death.

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

Your Rights

Programs providing treatment or services without the physical custody or where consumers do not remain for round-the-clock support or care, or where the facility does not have immediate control over the setting where a consumer resides, shall support and protect the fundamental human, civil, and constitutional rights of the individual consumer.

- Each consumer has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.

- Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
- 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.
- 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.
- A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be a bridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law.
- 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 with the consumer's consent;**
    - **To be free from unnecessary, inappropriate, or excessive treatment;**
    - **To participate in consumer's own treatment planning;**
    - **To receive treatment for co-occurring disorders if present;**
    - **To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and**
    - **To not be discharged for displaying symptoms of the consumer's disorder.**
    - **Every consumer's record shall be treated in a confidential manner.**
    - **No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.**
    - **A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.**
    - **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.**
    - **No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.**

For additional information regarding this notice and your rights, or to report any complaints regarding privacy issues, contact:

- Hope Revealed Behavioral Health Center, Inc.'s Coordinator and Local Advocate:

    Whitney Elliott
    1605 N. Harrison St., Shawnee, OK 74804
    405-481-7187; FAX 405-481-7219

- ODMHSAS Office of Consumer Advocacy
- ODMHSAS Office of the Inspector General