Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

Dear Parent or Guardian,

Thank you for choosing Hope Revealed Behavioral Health Center, Inc. for your child's 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 for your child, 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:

- Demographic Sheet
- Child History Questionnaire
- The SNAP-IV Teacher and Parent Rating Scale
- Release of Information
- Consent for Treatment
- Patient Rights

Please include when returning:

- A Copy of the front and back of your child's insurance card(s)
- Guardianship letter, if necessary, or
- Custodial court documents, if necessary

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 and your child.

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 PARENTS 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 your child's name, Soonercare id number and date of birth 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: _____

HOPE REVEALED

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Client's Name (Last, First MI) _____

Client's Date of Birth ___/___/___ **Gender** ___

CHILD'S RACE/ETHNICITY:

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

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

Home Telephone _____ **Cell Phone Number** _____

Email Address _____ **With whom does the child live?** _____

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)

- ☐ Behavior Problems
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Visual Hallucinations
- ☐ Developmental Disorder
- ☐ Autism
- ☐ Oppositional Defiant Disorder
- ☐ Audible Hallucinations
- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Other _____
- ☐ Suicidal Ideation
- ☐ Homicidal Ideation
- ☐ Custody/Court/Legal
- ☐ Depression

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

- ◯ Pediatrician/Primary Care
- ◯ Friend/Family
- ◯ School/Teacher
- ◯ 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: _____ Policy/Identification Number: _____

Subscriber's/Policy Holder's Name: _____ Group Name: _____

Subscriber's/Policy Holder's Date of Birth: ___/___/___ Group Number: _____

Parent/Guardian's Name: _____ Date of Birth: ___/___/___

Address: _____ City, State, Zip: _____

Phone Number: _____ Profession and/or work activity: _____

Parent/Guardian's Name: _____ Date of Birth: ___/___/___

Address: _____ City, State, Zip: _____

Phone Number: _____ Profession and/or work activity: _____

EMERGENCY CONTACT (Other than parent/guardian)

Name: _____ Relationship to child: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

CHILD'S RELIGION

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

Client's Name:
Identifier:

HOPE REVEALED
BEHAVIORAL HEALTH CENTER INC.
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Is the child adopted? ◯ Yes ◯ No

Other children in the family?

Name	Gender	Date of Birth	Relation to Child
		/ /	
		/ /	
		/ /	

LANGUAGES SPOKEN IN THE HOME

Are there other people living or temporarily staying in the home?

FAMILY HISTORY

Please list any medical or psychiatric illness in your family (parents, siblings, grandparents, aunts/uncles):

PREGNANCY HISTORY

During pregnancy with this child did the mother experience any of the following?

◯ Medical Problems
◯ Special Diet
◯ Medications
◯ Full-term (38-42 weeks) ◯ Other than full-term

Any accidents/injuries ◯ No ◯ Yes

BIRTH HISTORY
Age of mother at birth of child?

Complications for mother during delivery? ◯ No ◯ Yes

Child's birth weight: Was Oxygen needed? ◯ No ◯ Yes

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Special care? ◯ No ◯ Yes

How long did the child stay in the hospital after birth? _____

How long did mother stay in hospital after birth? _____

Describe your child in the first 6 months:

Easy baby	◯ No	◯ Yes
Enjoys people	◯ No	◯ Yes
Irritable	◯ No	◯ Yes
Difficult to sooth	◯ No	◯ Yes
Sleep/wake cycle poorly regulated	◯ No	◯ Yes
Unusually quiet	◯ No	◯ Yes
Unusually sick	◯ No	◯ Yes
Feeding difficulties	◯ No	◯ Yes
Strong reaction to light/sound/touch	◯ No	◯ Yes
Colic	◯ No	◯ Yes

CHILD'S EARLY DEVELOPMENT

Did the following events occur at **AGE APPROPRIATE** times?

Sat without support	◯ No	◯ Yes
Crawled	◯ No	◯ Yes
Walked without support	◯ No	◯ Yes
Used single words (other than mama or papa)	◯ No	◯ Yes
Used 2-3 word sentences	◯ No	◯ Yes
First began to sleep through the night	◯ No	◯ Yes
Daytime wetting stopped	◯ No	◯ Yes
Bed-wetting stopped	◯ No	◯ Yes
Bowel control	◯ No	◯ Yes

Client's Name:

Identifier:

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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CHILD'S MEDICAL HISTORY

Child's Primary Care Physician

Address

City, State, Zip

Phone number

Does your child have any allergies (environmental, food, medication)? ○ No ○ Yes

Does your child take any medications (include: vitamins, over the counter drugs and herbal medication.)

Has your child ever been hospitalized for any reason? (If so, please give details.)

Does your child have a current or past history of any of the following? (If so, please explain):

Head injury	○ No	○ Yes	
Broken bones	○ No	○ Yes	
Surgeries	○ No	○ Yes	
Birth defects	○ No	○ Yes	
Poisoning	○ No	○ Yes	
Heart problems	○ No	○ Yes	
Kidney problems	○ No	○ Yes	
Liver disease	○ No	○ Yes	
Lung disease	○ No	○ Yes	
Blood disease	○ No	○ Yes	
Cancer	○ No	○ Yes	
Seizure	○ No	○ Yes	
Other neurological problems	○ No	○ Yes	
Genetic Disorder	○ No	○ Yes	
Diabetes	○ No	○ Yes	
Thyroid	○ No	○ Yes	

Client's Name:

Identifier:

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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Skin problems	○ No	○ Yes	
Lyme Disease	○ No	○ Yes	
Impaired sight	○ No	○ Yes	
Impaired hearing	○ No	○ Yes	
Speech difficulty	○ No	○ Yes	
Eating disorder	○ No	○ Yes	
Sleep Apnea	○ No	○ Yes	
Severe vomiting	○ No	○ Yes	
Choking events	○ No	○ Yes	
Other problems	○ No	○ Yes	

SOCIAL DEVELOPMENT

Does your child make friends easily? ○ No ○ Yes

Does your child have difficulty interacting with others children?

Does your child have difficulty interacting with adults?

Does your child have a "Best Friend"?

BEHAVIORAL DEVELOPMENT

Does your child exhibit aggression to people or animals ○ No ○ Yes
(If yes, please explain)

Does your child often bully, threaten or intimidate others?

Does your child deliberately destroy others' property?

Does your child often lie to obtain goods or favors or to avoid obligations?

Has your child ever ran away from home?

Is your child often truant from school?

Client's Name:
Identifier:

HOPE REVEALED
BEHAVIORAL HEALTH CENTER INC.
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PRESCHOOL/SCHOOL HISTORY

Is your child attending preschool or school?

Name of school: Grade:

Does your child attend any special classes or receive any special education services?

Has your child ever repeated a grade in school or been "Held-back" for any reason?

Does your child have any learning or behavioral problems in school?

Has your child been suspended or expelled from school? (If yes, please indicate the reason).

SLEEP HABITS

What time does your child generally go to bed?

What time does your child generally wake up?

How many hours does your child sleep per nights?

Does your child stay asleep all night?

Does your child snore or seem to gasp for air during the nights?

STRESSORS

Is your child facing significant stressors at this time?
Please describe:

Is your family facing any significant stressors at this time?
Please describe:

Is there anything else you would like us to know that would assist us in understanding your child.

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the parent/guardian of _____, 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 child's 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.

Client Signature _____ Date of Birth ____ / ____ / _____ Date _____

Name of Parent/Legal Guardian _____ Date _____

Signature of Parent/Legal Guardian _____

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"

CONSENT TO RECEIVE OUTPATIENT BEHAVIORAL HEALTH SERVICES

I give consent for my child, _____, 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 allow my child to participate in program activities directly associated with his/her behavioral health evaluation and treatment, and as appropriate, to involve my child's family members. I authorize Hope Revealed Behavioral Health Center, Inc. to review my child's medical record for teaching, quality and audit purposes. I understand that the personal information that I provide about my child and our family will remain confidential and any published data will keep the identity of my child and family confidential. I declare that I am this child's legal guardian.

SEPARATION, DIVORCE AND CHILD CUSTODY

A copy of your custody decree and/or divorce decree, which is an official court document signed by a judge, if necessary, is required.

MINOR CHILDREN IN THE CUSTODY OF THE OKLAHOMA DEPARTMENT OF HUMAN SERVICES (DHS)

A copy of the DHS consent for treatment, signed by the DHS case worker and a copy of the DHS case worker's identification card is required.

LEGAL GUARDIAN OR GUARDIAN AD LITEM

A copy of a court order, which is an official court document signed by a judge, is required. The responsibilities and limits on the authority of the guardian must be stated in the court order.

DISCONTINUATION OF TREATMENT POLICY

Please be aware that Hope Revealed Behavioral Health Center, Inc. may discontinue your child's 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 of your child, and acknowledge that a parent or legal guardian agrees to be involved in the therapy process when necessary.

Printed Name of Parent/Guardian	**Signature**	**Date**
Printed Name of Client	**Signature (If child is 14 or above)**	**Date**
Signature of Witness (Clinician)	**Date**	

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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PATIENT/CLIENT BILL OF RIGHTS

As a patient/client at Hope Revealed Behavioral Health Center, Inc. you and your child 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 child's treatment in advance.
- To know the name and professional status of those persons providing your child's 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 child's treatment and his/her medical record. Information your child's record will be released only with your written permission. However, all Hope Revealed staff involved with your child's 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 child's 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 child's Individualized Treatment Plan and work toward achievement of treatment goals.
- To be honest with staff by sharing anything that might impact your child's 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 child's treatment.
- To inform staff of your desire to terminate treatment, especially if you have achieved your treatment goals.

Printed Name of Parent/Guardian	**Signature**	**Date**
Printed Name of Client	**Signature** (If child is 14 or above)	**Date**
Signature of Witness (Clinician)	**Date**	

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

"Healing yesterday, giving hope for tomorrow"

CONSENT, AUTHORIZATION AND ASSIGNMENT OF INSURANCE AGREEMENT

On behalf of my child, _____, 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 true 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 this 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 Parent/Guardian	**Signature**	**Date**
Printed Name of Client	**Signature (If child is 14 or above)**	**Date**

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 Parent/Guardian	**Signature of Parent/Guardian**	**Date**
Child's Name		
Signature of Witness (Clinician)	**Date**	

Client's Name: _____

Identifier: _____

HOPE REVEALED

BEHAVIORAL HEALTH CENTER INC.

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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 Parent/Guardian	**Signature**	**Date**
Printed Name of Client	**Signature (If child is 14 or above)**	**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 Local Advocate:
  Whitney Elliott, CMII,
  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,