Access Behavioral Health Services, Inc.

Client Information

Today's Date: _____ Social Security Number: ___/___/_____

Last Name	First Name	M.I.	Preferred Name	Date of Birth	Gender:
					☐ Female ☐ Male

Parent and /or Legal Guardian :		
	Relationship to Client:	
Address:		

Main Phone Number:		☐ Home ☐ Work ☐ Mobile ☐ Other
Alternate Phone Number:		☐ Home ☐ Work ☐ Mobile ☐ Other

Email Address:		Appointment Reminder Method:	☐ Call ☐ Text ☐ Email

Emergency Contact Name:	Relationship:	Contact Phone:	Work Phone:

Pharmacy Name:		Address:	

Preferred Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Korean ☐ Portuguese ☐ Russian ☐ Spanish

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity: ☐ Not Hispanic ☐ Hispanic

Education Level: ☐ less than a high school diploma ☐ high school graduate, no college ☐ some college or associate degree ☐ Bachelor's degree or higher

Smoking Status: ☐ current everyday smoker ☐ current some day smoker ☐ former smoker ☐ never smoker

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Access Behavioral Health Services, Inc. I understand that I am financially responsible for any balance. I also authorize Access Behavioral Health Services, Inc. or my insurance company to release any information required to process my claims.
By signing below, I understand if any charges I agree to are not paid, any outstanding balances over 120 days can and will be sent to collections.

Client/Parent Signature: _____

Access Behavioral Health Services, Inc.

Consent to Disclose Health Information for
Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Access Behavioral Health Services, Inc. (hereby known as Access), for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of Access. I understand that diagnosis or treatment of me by Access may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Access is not required to agree to the restrictions that I may request. However, if Access agrees to a restriction that I request, the restriction is binding on Access. The privacy officer, Laura Scuri, is the only authorized individual that can enter into this agreement on behalf of the company. I have the right to revoke this consent, in writing, at any time, except to the extent that Access has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, nurse practitioner, psychologist, therapist, case manager, psychosocial rehabilitation specialist, other treatment staff, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in performance or healthcare operations of Access Behavioral Health Services, Inc.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Witness Date

Client Rights

Each person receiving services through Access designated under these rules shall be ensured the following rights:

01. Idaho Code Sections 66-412 and 66-413, Idaho Code, provides the following rights.

    a. Humane care and treatment; and
    b. Not be put in isolation; and
    c. Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others; and
    d. Be free of mental and physical abuse; and
    e. Communicate by telephone or otherwise and to have access to private area to make telephone calls and receive visitors; and
    f. Receive visitors at all reasonable times and to associate freely with persons of his own choices; and
    g. Voice grievances and recommend changes in policies or services being offered; and
    h. Practice his/her own religion; and
    i. Wear his/her own clothing and to retain and use personal possessions; and
    j. Be informed of his medical and habilitative condition, of services available at the agency and the charges for the services; and
    k. Reasonable access to all records concerning him/her-self; and
    l. Refuse services; and
    m. Exercise all civil rights, unless limited by prior court order.

02. Additional Client Rights. The agency shall also ensure the following rights. The right to:

    a. Privacy and confidentiality; and
    b. Be treated in a courteous manner;
    c. Be free from discrimination based upon race, color, sex, national origin, disability, religion, age, sexual orientation or gender identity; and
    d. Receive a response from the agency to any request made within a reasonable time frame; and
    e. Receive services which enhance the client's social image and personal competencies and, whenever possible, promote inclusion in the community; and
    f. Refuse to perform services for the agency. If the client is hired to perform services for the agency the wage paid shall be consistent with state and federal law; and
    g. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; and
    h. All other rights established by law; and
    i. Be protected from harm.

_____ _____

Signature Date

_____ _____

Witness Date

Access Behavioral Health Services, Inc.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF HEALTH INFORMATION - We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We may use or disclose identifiable information about you as allowed or required by law. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses or disclosures. We may change our policies at any time. Before we make significant changes in our policies, we will change our notice and post the new policy in our waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices please contact Laura Scuri at the above number.

INDIVIDUAL RIGHTS - In most cases, you have the right to look at and/or get a copy of health information about you that has been generated by Access Behavioral Health Services, Inc. We may limit your access to your personal information if we determine that providing the information could possibly harm you or another person. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons than treatment, payment, or related administrative purposes. You are entitled to such an accounting for the six years prior to your request. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information and/or add the missing information. We may decline your request to amend the record for certain reasons including if you ask us to change information that we did not create.

COMPLAINTS - You may contact Laura Scuri if you are concerned we have violated your privacy rights or if you disagree with a decision we made regarding your record. You may also send a written complaint to the U.S. Department of Health and Human Services. Laura Scuri can provide you with the appropriate address upon request.

OUR LEGAL DUTY - We are required by law to protect the privacy of your information, provide you with this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Signature:

Printed name: _____ Date: _____

Witness: _____ Date: _____

Access Behavioral Health Service, Inc.
Grievance Policy for Consumers

SUGGESTIONS FOR IMPROVEMENT

Consumer's suggestions are an important part of providing effective care. Consumers are welcome to submit ideas for improvement to any program to an employee via written or verbal suggestions. We take all ideas seriously and if done in writing, the consumer will receive a written response. The grievance policy will be given to consumers at the initiation of services and then annually.

COMPLAINT PROCESS

It is the practice of Access Behavioral Health Services to resolve consumer/parent concerns, issues and complaints on an informal basis as part of the regular delivery of service. Informal complaints are to be handled promptly by the consumer's service provider or by the program director. In the event that a consumer complaint involves a private provider, the complaint will be submitted to the Program Director. Every effort will be made by providers, and/or the management team to resolve problems or complaints from clients at an informal level as quickly and as simply as possible.

Clients may ask for the assistance of the Program Director or Team Leader in resolving complaints regarding the provision of mental health services. Other persons may serve as advocates, such as family members or friends, at the request of the consumer. Clients/parents may ask questions, ask for a new therapist or Service Coordinator, or CBRS or complain about the services they receive without reprisal.

All providers and Management personnel will maintain a log of complaints. As part of on-going program monitoring, the board of directors will discuss issues identified as a result of the complaint resolution process on in order to address any needed system changes.

GRIEVANCE PROCEDURE

INTRODUCTION

The grievance procedure provides a formal avenue for the resolution of consumer concerns when the informal process is not sufficient to resolve the problem. A complaint becomes a grievance when it is put in written form and submitted to the board of directors or anyone else at the client's request. While the use of the complaint process to resolve issues promptly and informally is to be encouraged, a grievance may be filed without a complaint and without reprisal at any stage of the process. This is to be made clear to all clients. Assistance for documentation will be made immediately available upon request.

STEPS OF THE GRIEVANCE PROCEDURE

All Grievances will be submitted to the board of directors. The Grievance Procedure involves two basic steps:

> **Step 1:** Grievance, reviewed by Quality Improvement and referred to the appropriate Access BHS Administrative section for investigation and resolution.
>
> **Step 2:** Final Appeal, reviewed by Quality Improvement and referred to the Director of the program. The Director may assign an independent third party or parties for review of grievances at his/her discretion.

Clients/parents may ask questions, ask for a new provider, make requests and complain or grieve about the services they receive without reprisal.

In implementing the grievance procedure, staff are asked to remember that:

- The unique individual merits of each case need to be heard.
- It is possible to deviate from technical adherence to this procedure if warranted to protect the consumer as long as no rights or guarantees are violated and the consumer has given consent.
- A written acknowledgement will be issued by the board of directors within 5 working days of receipt of a grievance.

CONFIDENTIALITY

This policy is to be implemented consistent with laws and regulations regarding confidentiality for consumers.

ADDITION TO EXISTING RIGHTS

Use of this grievance procedure does not replace any existing avenues of review or redress provided by law. Consumers have full access to the grievance procedure and to all rights guaranteed under the law.

INFORMING CONSUMERS ABOUT THE GRIEVANCE PROCEDURE

1. A copy of this policy is to be available at all direct treatment programs for review by consumers upon request.
2. Staff shall inform consumers about the complaint and grievance procedures:
    a. at the initial face to face evaluation,
    b. at admission to any new program or private provider,
    c. at least annually during treatment reauthorization

FILING GRIEVANCES AND APPEALS

1. **Grievances may be filed by consumer, their family members and support persons.** This includes:
    a. Consumers age 18 or over
    b. Parents/guardians of children and youth receiving services
    c. Youth between the ages of 14 and 18 who are receiving services, if their position is different from that of their parent/guardian.
    d. Family members of consumers ("Family" is defined to include close personal friends and support persons.)
2. While Access BHS encourages programs to resolve consumer complaints informally whenever possible, invoking this grievance procedure is always at the consumer's discretion.
3. Parents, guardians and youth have several grievance procedures they may use in addition the Access BHS procedure. To determine the procedure that will be most responsive to their concerns, they should be encouraged to contact:
    a. Optum: 1-855-202-0973
    b. Co-Ad: 336-5353

For general information about this procedure, grievant may contact
Laura Scuri or Nikki Tangen at 338-4699.

4. Grievant may use a personal representative of their choice to assist them in this process at any time.

   Representatives may include, but are not limited to:

   Family members
   Friends
   Other consumers
   Trained advocates
   Staff

   Parents and guardians of minors and children of any age may contact a certified representative from the list posted at the program.

5. If a personal representative is not employed by Access BH, confidentiality must be protected:

   a. The consumer, including the child, must sign a "Release of Information" form available at all sites, in order to allow Access BHS to discuss the issues with the representative present.

6. Grievants are to be required to submit their grievance or appeal in writing. Assistance may be obtained from anyone a participant is comfortable getting assistance from. Grievants are to be given a copy of their written grievance/appeal upon request.

7. Grievances and Appeals are filed with:

   Laura Scuri or Nikki Tangen
   1276 W. River St. suite 100

   Boise, Idaho 83702

   Fax: 208-322-4722

DENIAL OR DISCONTINUING SERVICES DURING GRIEVANCE PROCEDURE

When a consumer is denied services because of medical necessity criteria

1. They have right to a face-to-face assessment if they disagree with the denial. A face-to-face assessment must be done before a final appeal is filed.
2. When a consumer files a grievance because they are being terminated from a program or because their level of frequency of service is being reduced, services are to continue until the grievance is resolved or a response to the initial appeal is given to the consumer. If the decision is being dictated by Optum Access BHS will provide the client with the contact information for Optum and will assist with any appeal process.

RESPONDING TO GRIEVANCES AND APPEALS

1. When a grievance or appeal is filed, staff are to respond promptly**.** A written acknowledgement will be issued by the board of directors within 5 working days of receipt of a formal grievance. Step 1 of the Grievance requires *personal contact* with the grievant whenever possible. While Step 2 may be conducted through a paper review, *personal contact is always preferable*.

RETENTION OF RECORDS

1. A copy of all grievances and appeals is to be retained for 3 years.
2. As required by Credentialing procedures, the Quality Management Section maintains a log of all grievances. This log contains at least the following information on each grievance and appeal:
    - date filed
    - grievant name
    - program name
    - staff name if grievance is filed against a particular staff person
    - type of problem
    - date of response
    - type of response

QUALITY IMPROVEMENT

1. All formal grievances will be reviewed by the board of directors. Pro-active steps will be taken to ensure compliance with this policy and prevention of further issues depending on the nature of the grievance. All reviews will be documented and corrective action will be documented and reviewed for compliance.

Grievance Policy Acknowledgement

I have received the Grievance Policy from Access Behavioral Health Services. Printed

_____

Name

_____ _____

Participant Signature (if 14 years old or older) Date

_____ _____

Parent/Guardian (if applicable) Date

Access Behavioral Health Services

Consent for treatment and services for Psychotherapy and Medication Management and Community Based Rehabilitation

Risks and Benefits of Therapy

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things talked about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Program Description for Psychosicial Rehabilitation

Community Based Rehabilitation is an Optum reimbursed prior authorized community based program for adults with severe and persistent mental illness, and children with severe emotional disturbances. CBRS is a program designed to promote recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs functioning. CBRS services are collaborative, person directed, and individualized, and an essential element of the human services spectrum. CBRS Specialists focus on helping individuals re-discover skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice. CBRS services directly address the high risks that many persons with serious and persistent mental illness or severe emotional disturbance experience of repeated hospitalizations, high utilization of emergency room services, low levels of functioning in the community, poor performance in educational settings, risk of out of home placement, homelessness, and unemployment.

Limits of Confidentiality

While the right to privacy binds all providers of Mental Health Services, there are limitations. Some specific limitations of confidentiality are:

- When the client waives their right to privacy and gives written consent
- When, based on sound clinical judgment, disclosure is required to prevent clear and imminent danger to the client or others and the client is unwilling or unable to contract for safety
- In matters affecting the welfare or abuse of children
- When ordered by an official of the court as required by law

Periodically, a client's information may be reviewed for the purposes of a treatment team, supervisory status, or clinical peer review, and others may have access to the file or information pertaining to the client. In the event of one of the above stated instances, the provider of services will disclose only what is essential information required by the given circumstance.

Focus of Service

All clients have the right to be informed of the goals and purposes, limitations, possible risks, and the benefits of services to be performed. Goals of treatment and procedures to be used will be agreed upon by the client and

provider through the signatures on the treatment plan. Clients are encouraged to ask questions and have the right to have such questions answered in terms clearly understood by the client.

Appointment duration, times, and frequency will be determined based on the individual needs of the client. The duration of treatment will be determined by client's progress, the desired goals of the client, and mutual agreement between the provider and the client. The client has the right to terminate or refuse treatment at any time for any reason.

The provider does not use video or tape recording devices without prior consent of the client. Clients have the right to have access to and view their records at any time. However, these records are maintained and owned by the provider. Access to these records is limited to all other individuals unless given prior consent by the client, when required by law, and in situations involving minors, under the age of 16.

Financial Arrangements

We primarily work with m a n y insurance companies for reimbursement of services. Please call our office or your insurance company to see if we are contracted with a specific provider. We will be happy to file a claim; however, any co-payment is due before seeing a provider. Cash paying clients need to pay the full amount unless other arrangements have been made. By signing this document, I authorize Access BHS to bill my insurance.

If you expect to use insurance to obtain reimbursement for services, please check your current coverage carefully. Call the phone number on your card and ask about your mental health benefits. Some insurance plans require advance authorization before they will reimburse for mental health services. Often they will only pre-approve a limited number of sessions, and it will be necessary to seek approval if additional sessions are needed. Please remember that you, and not your insurance company or a third party payer, are responsible for full payment of the fee.

CBRS is Optum/Medicaid reimbursed services. Access Behavioral Health Services, Inc. does accept a limited number of private pay clients for services, however there must be an agreement for payment in place prior to providing services. Consumers with Medicaid are not expected to provide payment for CBRS, as this is a fully reimbursed service from your Medicaid health insurance coverage.

Cancellation

The provider will make all efforts to be there for your appointment and, in turn, expects you will do the same. When you make an appointment, we reserve that time specifically for you. You are requested to notify us as soon as possible, but no later than 24 hours in advance, if you need to cancel or reschedule an appointment.

CBRS Risks

It is important to understand that there are risks associated with any type of psychiatric treatment. Patients may experience psychiatric decompensation, increased severity of negative symptoms, or an increase in negative behaviors. Other issues may be identified during treatment that were not recognized before. There may also not be any effect of this treatment. The CBRS services you are consenting to receive are being delivered by individuals that may have a bachelor's degree from an accredited university, and are to be delivered in community settings.

CBRS Benefits

CBRS is designed to teach the individual to maximize their performance in identified life areas. It is a well-documented and researched model that shows positive influence and positive growth from its participants. Consumers receiving CBRS often report that they are better able to meet their daily needs, feel that their negative symptoms impact their life significantly less, experience fewer, if any, hospitalizations, are better able to cope with day to day stressors, and are able to meet their personal goals for obtaining a quality of life,

completing their education, remaining in their desired living situation, and being able to participate in activities that they enjoy.

Availability

Access Behavioral Health Services, Inc. provides 24-hour crisis support for after hours psychiatric emergencies for individuals receiving CBRS. If you are experiencing psychiatric crisis you or your caregiver may contact us at 208 713 9488. The crisis phone is maintained by bachelor level PSR specialists who are available to problem solve, advocate, or make referrals as appropriate. In addition 24-hour crisis support for after hours emergencies for individuals receiving clinic services can be access at 208297 9273. The clinic crisis phone in maintained by a master level certified therapist.

Consumer Choice

There are many agencies in your area that provide mental health services. You will always have the right to choose which agency you work with to provide any of your mental health services. Access Behavioral Health Services, Inc. can provide you with a regional list of all of the known providers at your request. Please contact the front desk to review that list. Access BHS will work with any provider you choose to ensure you receive a smooth transition and quality services, however, it should be clearly addressed that all transitions can decrease the efficacy of services or even cause a lapse in services. We encourage all consumers to work with their current agency to resolve any issues prior to switching agencies.

Minors

Parental involvement in mental health treatment is critical for children to make progress toward their goals. Access Behavioral Health Services, Inc. therefore requires parents or guardians of children under the age of 18 to sign all required documents and be available for regular consultation to discuss progress, barriers, and exchange information on the child's status. Failure to cooperate could result in the termination of services for the child.

Records

The laws and standards of the mental health profession require that Access Behavioral Health Services, Inc. keeps treatment records. You are entitled to receive a copy of the records unless it is believed that seeing them would be emotionally damaging, in which case your provider will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Access Behavioral Health recommends that you review them in your provider's presence so that you can discuss the contents.

Permission to Treat

I acknowledge that it is my choice to participate in mental health treatment (or have my child participate). I will take responsibility for my treatment and will be prepared and ready for each session.

Your signature acknowledges agreement and understanding:

_____ _____

Client Signature Date

_____ _____

Witness Date

Adult Service Coordination
INFORMED CONSENT/CHOICE FORM

The Purpose of Service Coordination:

Service Coordination is an optional case management activity reimbursed by Medicaid, which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care, and services appropriate to the needs of the individual.

Through Service Coordination, a Service Coordinator will:

1. assisting you in accessing and coordinating supports and services,
2. advocate for your unmet needs and assure that supports and services meet your needs, and
3. Encourage independence.

Your Service Coordinator is responsible for completing an Assessment and writing a Service Coordination Plan reflecting current services and supports and defining needed services and supports.

You have the right to …

1. Refuse service coordination or discontinue service coordination at any time. Service coordination is an optional service and is not required to access other developmental services.
2. Choose service coordinators and all other providers.
3. change service coordinators or agencies at any time, either by:
   a. requesting a change in coordinators from your present agency, or
   b. contacting Health & Welfare at
      to request an agency change and/or list of available agencies; or
   c. requesting that a new service agency process the change application.
4. Choose with whom you meet and how often. A 'face to face' meeting is required once a month between you and the Service Coordinator, but you are entitled to more than one face to face.

PRINT NAME: _____DOB:_____

I select:

_____

Name of Service Coordinator and Service Coordination Agency

_____ _____*

SIGNATURE of Client **Date of Choice**

Children's Service Coordination
INFORMED CONSENT/CHOICE FORM

The Purpose of Service Coordination:

Service Coordination is an optional case management activity reimbursed by Medicaid, which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care, and services appropriate to the needs of the individual.

Through Service Coordination, a Service Coordinator will:

1. assisting you in accessing and coordinating supports and services,
2. advocate for your child's unmet needs and assure that supports and services meet your child's needs, and
3. Encourage independence.

Your Service Coordinator is responsible for completing an Assessment and writing a Service Coordination Plan reflecting current services and supports and defining needed services and supports. A Service Coordinator may be assisted by a paraprofessional in implementing the Service Coordination Plan.

You have the right to …

1. Refuse service coordination or discontinue service coordination at any time. Service coordination is an optional service and is not required to access other developmental services for your child.
2. Choose service coordinators and all other providers.
3. change service coordinators or agencies at any time, either by:
   a. requesting a change in coordinators from your present agency, or
   b. contacting Health & Welfare at
      to request an agency change and/or list of available agencies; or
   c. requesting that a new service agency process the change application.
4. Choose with whom you meet and how often. A 'face to face' meeting is required every 90 days between the Service Coordinator and the child receiving service coordination, but you can request a more frequent meeting with you or your child.

PRINT CHILD'S NAME: _____DOB:_____

PRINT PARENT/GUARDIAN NAME: _____

I select:

_Access Behavioral Health Services _____
Name of Service Coordinator and Service Coordination Agency

_____ _____*
SIGNATURE OF PARENT/GUARDIAN **Date of Choice**

Access Behavioral Health Services

Medication Refill Policy

At Access Behavioral Health Services we strive to ensure clients have their medications refilled in a timely manner. Due to the amount of refill requests we receive and the time constraints of our medical providers we ask that our clients do the following to ensure they have their needed medications

- Contact your pharmacy first to have your medication refilled and the pharmacy will fax a request to the appropriate office
- If a hard script is required for a controlled substance contact the appropriate office a week prior to the medication being needed

Refills may not be available the same day a refill is requested due to medical providers not being available. Please note there will be a minimum of two working days response time from the time we receive your request to the time it is authorized. In cases when the medical provider does not feel it is in the client's best interest to refill the medication(s) the client will be contacted to come in and have an appointment with the medical provider.

If a client has missed a medication management appointment it may not be possible for the medical providers to refill a medication, these appointments are essential to the health and safety of our clients.

In an effort to avoid medication refill emergencies please plan at least 10 days ahead for medication refill requests.

_____ _____

Client Date

_____ _____

Parent or Guardian Date

_____ _____

Witness Date

Access Behavioral Health Service, Inc.
No Show/Cancellation Policy

In order to provide the highest quality care to our patients, we have established a formal "No Show /Cancellation Policy". We understand that there may be circumstances that require you to cancel an appointment, but we require that you notify our office no less than 24 hours in advance. Your appointment time has been reserved for you for your treatment.

When you no show or cancel an appointment, the failure to keep your scheduled appointment is documented. Should these events occur in more than two (2) instances, services could be suspended.

We do understand that unusual circumstances arise which may have prohibited you from canceling your appointment with advance notice. Please discuss these situations with us and under certain circumstances, we may determine to continue to provide treatment. If your services have been terminated and you would like them continued please write a letter to Nikki or Laura with an explanation of why your treatment should be continued and what measures you are taking to not continue to miss appointments.

It is our intention that this policy be clear and concise and that it underscores the importance of keeping scheduled appointments. We want to clearly state consequences if this policy is not adhered to. This is being done in an effort to respect the schedules of everyone involved.

By signing below, I acknowledge and understand Access Behavioral Health Services' "No Show/Cancellation Policy.

_____ _____
Client/Guardian Date

_____ _____
Witness Date

Access Behavioral Health Services

CONSENT TO TRANSPORT

I, _____ as parent and legal guardian of _____ authorize and give my permission for Access Behavioral Health Services and its employees to transport my child as needed when providing mental health services in the community. By signing below I agree to hold harmless Access and its employees, agents, and successors, from any and all action that may occur while transportation is taking place.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Access Behavioral Health Services

EMERGENCY TREATMENT AUTHORIZATION – MEDICAL RELEASE

I, _____(parent /guardian) hereby consent for Access Behavioral Health Services to seek emergency medical treatment for _____ (child). This consent is given in advance of any treatment or diagnoses as needed.

I designate _____ M.D. as a primary physician. I designate the following medical professionals as consultants in their specific fields:

These designations do not limit emergency services. This authorization will remain current throughout ongoing treatment.
Please list any restrictions for medical care or other care providers:

Disclaimer: In the event that your child is injured or needs emergency care, Access Behavioral Health Services, its employees, physicians or subcontractors will not be held liable for any costs incurred in seeking such treatment.

_____ _____
Parent/Guardian/Authorized Representative Date

_____ _____
Witness Date

OR YOU MAY DECLINE EMERGENCY MEDICAL TREATMENT BY FILLING OUT THE INFORMATION BELOW:

I, _____(parent /guardian) hereby decline emergency medical treatment for my

child_____ (child). Access Behavioral Health Services will not be held liable for NOT

seeking medical services for my child.

_____ _____
Parent/Guardian/Authorized Representative Date

_____ _____
Witness Date

Access Behavioral Health Services Inc.,

Client Choice Form Psycho Social Rehab

Under the Idaho Code # 03.09116 individuals with a mental illness may be eligible for Psycho Social Rehabilitation services. The purpose of these services is to assist eligible individuals to gain independence for assessed problems with medical, social, educational, vocational, financial, mental health, and other areas of living. Individuals filling out this form have been pre-screened for Psycho Social Rehabilitation services and have met the guidelines set forth by Medicaid. As a client of Access Behavioral Health Services, Inc. it is important that you understand that you have a choice of provider agencies that provide your PSR. By signing this form you are indicating that you have been informed of your rights to choose any service provider at any time for any reason. You also understand that changing agencies can cause psychiatric decompensation and an interruption in services. During this time you are allowed to maintain contact with any agency and have the right to a formalized transition process to ensure continuity of your care. It is against state policy to coerce any client into changing agencies. It must be the decision of the individual only to change agencies. Any agency offering items or extra services in exchange for you to switch to them is violating Medicaid Policy and best practice guidelines. Access Behavioral Health Services, Inc. will not engage in solicitation of clients but is supportive of the consumer's right to choose listed below is a partial listing of the other agencies as well as the number to call at Health & Welfare if you have questions or concerns. Ultimately all problems or concerns should be directed to the Mental Health Authority at the Department of Health and Welfare.

Access Behavioral Health Services, Inc.	208-338-4699
All Together Now	208-336-4504
Human Supports of Idaho	208-321-0160
Mountain States Group	208-336-5533
Region IV Mental Health Authority	208-334-0800

I have reviewed the list of private providers of Psycho Social Rehabilitation agencies and have chosen Access Behavioral Health Services, Inc. as my PSR provider agency. I have not been promised any services nor have I been solicited to switch agencies by any individual from Access Behavioral Health Services, Inc.

_____ _____

Client Signature Date

_____ _____

Witness Date

Access Behavioral Health Services
3307 Caldwell Blvd. Ste. 104
Nampa, Id 83651
Ph: 208-465-4833 Fax: 208-467-2654

Release of Information
Authorization for Disclosure

Client Name: DOB:

Client Home Address:

Phone: SS #:

Agency requesting or needing information:

Access Behavioral Health Services
3307 Caldwell Blvd. Ste. 104
Nampa, Id 83651

I authorize the following person or business to release or disclose confidential information about me:

Purpose of Disclosure:

Type of information to be disclosed __X__Psychiatric _____Drug/Alcohol _____ HIV/AIDS

Description of information requested:

This authorization is good until ____**1 yr**_____.

I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization. Copy requested and received _____Yes No _____ I do not want a copy of this.

I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

_____ _____
Client or guardian (individual over 14 both must sign) Date

_____ _____
Witness Date

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3307 Caldwell Blvd. Ste. 104
Nampa, Id 83651
Ph: 208-465-4833 Fax: 208-467-2654

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_____ _____
Client or guardian (individual over 14 both must sign) Date

_____ _____
Witness Date