Restore Outreach Center
4315 Bluebonnet Blvd ste B
Baton Rouge, LA 70809
Phone: 225-223-6968 Fax: 225-442-1396 Email: restoreoutreachcenter@gmail.com

Intake Form

DEMOGRAPHIC:

Client Name: _____ DOB: _____ Age: _____

Grade: _____ Gender: Male Female Other: _____ Ethnicity: _____

Medicaid Number: _____ Soc. Sec. Number: _____

Guardian Name: _____ Relationship: _____

CONTACT INFORMATION:

Phone Number: _____ Alternate Phone: _____

Address (No PO Box): _____

City: _____ State: _____ Zip Code: _____

Mailing Address (**if different**): _____

_____

EDUCATION: Is the client enrolled in school? _____ **School Name**: _____

PRESENTING PROBLEM(s): Please check all that apply

__ Anxiety	__ Fidgety	__ Phobias
__ Criminal behavior (such as stealing, breaking into houses and vandalism)	__ Fighting	__ Running away
__ Constant restlessness	__ Fire-setting	__ Suicidal
__ Cutting Self	__ Forgetting instructions	__ Talking back or arguing with parents/teachers
__ Defiance (not wanting to do what they are told)	__ Hitting or biting themselves	__ Temper tantrums
__ Depression	__ Hurting pets or other animals	__ Verbally threatening others
__ Destructiveness (e.g., destroying property)	__ Low self-esteem	
__ Difficulty concentrating	__ Lying	

Other: _____

PAST TREATMENT:

Has the client been diagnosed with a behavioral or mental disorder in the past? _____

If "Yes", what was it? _____

Was the client prescribed any medication for this diagnosis? _____ If "yes" what kind? _____

Has the client ever been enrolled in another agency/program? _____ If "yes" where? _____

Referral Source: _____

ASSESSMENT APPOINTMENT

Date: _____at _____

Name:
DOB:
Medicaid No.:

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AmeriHealth Caritas Louisiana

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member name: _____

Member ID number: _____ Member date of birth: _____

Member information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from one provider unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: **www.aetnabetterhealth.com/louisiana/find-provider** or call **1-855-242-0802 (TTY/TDD 711).**
2. Amerihealth Caritas Louisiana: **www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx** or call **1-888-756-0004 (TTY 1-866-428-7588).**
3. Healthy Blue: **www.myhealthybluela.com/la/care/find-a-doctor.html** or call **1-844-227-8350 (TTY/TTD 711).**
4. Louisiana Healthcare Connections: **https://providersearch.louisianahealthconnect.com** or call **1-866-595-8133 (TTY/TTD 711)**.
5. United Healthcare Community: **www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html** or call **1-866-675-1607 (TTY 1-877-4285-4514).**

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider name: Restore Outreach Center

Provider phone number: 225-223-6968

Provider contact name: Restore Outreach Center Licensed Clinician

Provider address: 4315 Bluebonnet Blvd Ste B Baton Rouge, LA 70809

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/legal guardian signature: _____ Date: _____

Printed legal guardian name (if applicable): _____

Provider's information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

Provider signature: _____ Date: _____

Name:
DOB:
Medicaid No.:

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Member Name (First, Last Name): Member DOB:
Member ID #:

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from **one provider** unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. Amerihealth Caritas Louisiana: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588
3. Healthy Blue: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. Louisiana Healthcare Connections: https://providersearch.louisianahealthconnect.com/ or call 1-866-595-8133 (Hearing Loss: 711)
5. United Healthcare Community: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider Name:	Restore Outreach Center
Provider Phone Number:	225-223-6968
Provider Contact Name:	Restore Outreach Center Licensed Clinician
Provider Address:	4315 Bluebonnet Blvd Ste B Baton Rouge, LA 70809

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/Legal Guardian Signature Date

Printed Legal Guardian Name (if applicable)

Providers Information: A Member Choice form is required prior to receiving any mental health rehabilitation services. . This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

Provider Signature Date

BLAPEC-0907-18 June 2018

Name:
DOB:
Medicaid No.:

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4315 Bluebonnet Blvd ste B
Baton Rouge, LA 70809
Phone: 225-223-6968 Fax: 225-442-1396 Email: restoreoutreachcenter@gmail.com

Member's Freedom of Choice

Restore Outreach Center, Baton Rouge, LA. Phone Number: 225-223-6968 Fax: 225-442-1396

I am aware that providers and facilities available to me can be found at 4315 Bluebonnet Blvd, Suite B in Baton Rouge, Louisiana. Additionally, the provider can be contacted by phone at 225-223-6968 and faxed at 225-442-1396.

The provider I choose is: (enter provider name and phone number in box)

Restore Outreach Center **4315 Bluebonnet Blvd, Suite B** **Baton Rouge, LA 70809** **225-223-6968**

By signing below, I acknowledge that I freely choose to receive services from the above provider, and I acknowledge my responsibility to notify my previous provider in order to coordinate care (member signature in box),

Member name:	Member date of birth:

Today's Date:

Instructions for provider:

A Freedom of Choice Form is required prior to service authorization. The form requires a member signature, date, and identified provider and provider telephone number. The provider assumes responsibility of coordinating care with the prior provider of record.

Parent/ Guardian's signature and date:

Provider Representative signature and date:

Name:
DOB:
Medicaid No.:

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Member Orientation Form

As a member, parent, or legal guardian of a member of RESTORE OUTREACH CENTER, you can expect to be instructed or given written information regarding the following, upon admission to RESTORE OUTREACH CENTER's Mental Health Program.

1. Member Rights & Responsibilities
2. Grievance and Appeal Procedures
3. Communication/input policies regarding:
   a) Quality of Care
   b) Outcome Achievement
   c) Member Satisfaction
4. Explanation of RESTORE OUTREACH CENTER's
   a) Mission/Philosophy
   b) Services, activities, and therapeutic interventions
   c) Expectations
   d) Hours of Operation
   e) 24-Hour On Call Policy
   f) Code of Ethics
   g) Confidentiality Policy
   h) Requirements for follow-up for mandated members, regardless of his/her discharge outcome.
5. Explanation of any and all financial obligations, fees, and arrangements for services provided by the organization.
6. Orientation with RESTORE OUTREACH CENTER facilities, including emergency exits, fire suppression equipment, and first aid kits.
7. RESTORE OUTREACH CENTER policies regarding:
   a) Smoking
   b) Illicit or licit drugs
   c) Weapons
   d) Abuse
8. Identification of service coordinator.
9. Program rules that identify:
   a) Any restrictions the program may place on members.
   b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the member.
   c) Means by which the member may regain rights or privileges that have been restricted.

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10. Education regarding Advanced Directives, where appropriate.
11. Identification of the purpose and process of assessment.
12. A description of how the Treatment Plan will be developed.
13. Information regarding transition criteria and procedures.

Client/ Legal Guardian Signature **Date**

Witness Signature **Date**

Name:
DOB:
Medicaid No.:

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Authorization for Emergency Medical Treatment

I, the recipient/guardian of _____, subject to the conditions set forth below. I consent to receive such medical treatment and/or surgical procedures necessary in the event of an emergency, and to assume liability for medical expenses involved. This authorization extends to my participation in any activity sponsored by Restore Outreach Center, as a whole, or by workers within each program site.

Should a medical emergency arise during my participation in a Restore Outreach sponsored event, I understand that reasonable efforts will be made to contact me or my designated emergency contact at the numbers listed below. If it is believed my life or health may be adversely affected by the delay that an attempt to contact me or my designated contact could cause.

I consent to the administration of medical treatment and/or surgical procedures as deemed necessary by the medical doctor and/or facility and to the immediate administration of life-sustaining measure(s) deemed necessary under the circumstances.

HEALTH INFORMATION:

Doctor's name or Clinic: _____ Phone: _____ Fax: _____

Allergies: _____

Medications: _____

Medical Problems (Diabetes, Epilepsy, etc.): _____

Does the client have an Advanced Directive? If yes, please provide Restore Outreach with a copy? ☐Yes ☐ No

Does the client have any communication barriers which may make it difficult to understand him/her? ☐Yes ☐ No

If yes, please explain: _____

Does the client have a history of Substance Abuse? ☐Yes ☐ No If yes, please explain:

INSURANCE INFORMATION:

Company: _____

Policy #: _____

Policy Holders Name and Relationship to Child: _____

CONTACT INFORMATION:

Recipient Name:_____

Parent/Guardian Name: _____

Address: _____

Home Phone #: _____ Alternative Phone #: _____

Alternate Contact Person: _____ Relationship: _____

Address: _____

Home Phone #: _____ Alternative Phone #: _____

Preferred Doctor/Medical Facility: _____

Phone: _____

Signature of Recipient/Parent or Guardian _____ **Date** _____

Name:
DOB:
Medicaid No.:

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CONSENT/ AUTHORIZATION FOR OUTPATIENT TREATMENT

I _____, do hereby authorize Restore Outreach Center, LLC it's consultants, therapists, medical staff employees, and whomever else may be necessary to administer outpatient therapy and or procedures that are considered necessary for my treatment.

I understand that various procedures and treatments may be used and that liability of Restore Outreach Center, LLC and its employees are limited only to negligence.

The services provided are as follows:

____ Assessment ____Group Counseling

____ Education ____ Family Counseling

____ Psychiatric Evaluation ____ Individual Counseling

____ PSR/CPST ____ Other_____

I, _____, give my permission to receive counseling/therapy services from Restore Outreach Center, LLC. I understand that by giving my permission to receive services, I have the right to withdraw my consent at any time. Withdrawal of my consent will result in my file being closed immediately. By giving my permission to receive services, I understand that I, as a client, have the right to confidentiality, the right to privileged communication, responsibilities I must uphold as a client and the right to refuse service at any time. I understand that I, as a client, have the right to give informed consent to individuals, agencies, and/or organizations to view my file. I understand that I, as a client, have the right to request, in writing, information in my file at any time.

I furthermore, give Restore Outreach Center, LLC staff to provide Emergency Medical Treatment if needed.

*Please Sign and Date

By signing below, I am agreeing that I have read and understand the above information.

Client Name: _____

Client Signature: _____ Date: _____
Parent/Guardian if client is under 18

Staff Signature: _____ Date: _____

Name:
DOB:
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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 VERY CAREFULLY.**

Restore Outreach Center, LLC HAS A LEGAL DUTY TO SAFEGUARD AND PROTECTED YOUR HEALTH INFORMATION. All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice, and to protect the privacy of your health information. This "protected health information" includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) your Protected Health Information. With some exceptions, we may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of the notice of privacy practices currently in effect. We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the Protected Health Information already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy from the contact person listed at the end of this notice at any time.
WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below, we describe the different categories of when we use and release your Protected Health Information without your consent.

A. **WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**.

1. **For Treatment**. We may share your Protected Health Information among physicians, nurses, psychologists, social workers, interns, and other health care personnel who are directly involved in your health care at this clinic. For example: your primary therapist and your medication provider will share your protected health information to provide the best care for you. For external disclosures we will always ask for your authorization before we disclose your health information, except in emergencies to other mental health agencies or units.

2. **To obtain payment for treatment.** We may use and release your Protected Health Information in order to bill -and collect payment from you for services provided to you. It is important that you provide us with correct and up-to-date information. For example, we may release portions of your Protected Health Information to our billing department to get paid for the health care services we provided to you. We may also release your Protected Health Information to our business associates, such as billing companies.

3. **To run our health care business**. We may use your Protected Health Information internally, in order to operate our facility in compliance with healthcare regulations. For example, we may use your Protected Health Information to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. **WE DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PROTECTED HEALTH INFORMATION**:
1. **When federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies request your Protected Health Information**. We release your Protected Health Information only when a law requires that we report information to government agencies or law enforcement personnel. Specifically, we would notify the State of Louisiana Child Abuse Registry about victims of child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred; in missing person cases; or when ordered in a judicial or administrative proceeding.

2. **About Decedents.** We provide coroners/medical examiners at their request, necessary information relating to an individual's death.

3. **To avoid harm**. In order to avoid a serious threat to your safety or the safety of another individual, we may provide your Protected Health Information to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.

4. For **appointment reminders and health-related benefits and services.** We may use your demographic Protected Health Information to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

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5. **For health oversight activities**. We report information about serious incidents, including deaths, to the Louisiana State Office of Mental Health. We may use and disclose your Protected Health Information to a health oversight agency, including the Louisiana State Office of Mental Health, Medicaid, Medicare, or your Health Insurance Plan, for oversight activities authorized by law, including audits, licensure, or other activities necessary for oversight of the health care system or disciplinary actions against our workforce.

C. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE.

1. **To obtain payment from your health care plan for treatment**. Pending your signed Consent for Release of information and Payment for Medical Benefits Form, we may use and release your Protected Health Information to your health plan in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to date information.

2. **Information shared with family, friends, or others.** We will only release your Protected Health Information to a family member, friend, or other person that you indicate is involved in your care if you agree to the disclosure by completing and signing an Authorization Form. We will ask for your written authorization before using or releasing any of your Protected Health Information. If you choose to sign an authorization to release your Protected Health Information, you may later cancel that authorization in writing. This will stop any future release of your Protected Health Information for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. **You Have the Right to Request Limits on How We Use and Release Your Protected Health Information.** If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit Protected Health Information that we are legally required or allowed to release.

B. **You Have the Right to Choose How We Communicate Protected Health Information to You.** All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

C. You **Have the Right to Request to See and Get Copies of Your Protected Health Information**. You must make the request in writing. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You may have the right to have the denial reviewed by a committee. You can request a summary or a copy of your Protected Health Information as long as you agree to the cost in advance. If your request to see your Health Information is approved, we will arrange this in accordance with established policy. Please submit all requests for this information to the Clinical Director Dr. Kashunda Williams.

D. **You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your Protected Health Information.** This list will not include uses you have already authorized, or those for treatment, payment or operations. This list will not include disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list will include dates when your Protected Health Information was released and the purpose, with whom your Protected Health Information was released (including their address if known), and a description of the information released. Any list you request within a 12-month period will be free. Please submit all requests for this information to the Office Manager: LaToya Burks.

E. **You have the Right to Correct or Update Your Protected Health Information**. If you believe that there is a mistake in your Protected Health Information or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your Protected Health Information. If we approve your request, we will make the change to your Protected Health Information, tell you that we have done it, and tell others that need to know about the change or amendment to your Protected Health Information. Please submit all requests for this information to the Clinical Director Dr. Kashunda Williams.

F. **You have the Right to Receive This Privacy Notice**.
You have the right to request another paper copy of this notice at any time.

Name:
DOB:
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HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your Protected Health Information, you may file a complaint with our Privacy Official listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES PLEASE CONTACT Restore Outreach Center LLC Clinical Director @ *225.223.6968*

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

By signing below, I acknowledge I have received a copy of Restore Outreach Center, LLC "Notice of Privacy Practices"

Client Name: _____

Client Signature: _____ Date: _____
Parent/Guardian if client is under 18

Staff Signature: _____ Date: _____

Name:
DOB:
Medicaid No.:

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RECIPIENT'S RIGHTS & RESPONSIBLITIES

ACKNOWLEDGMENT

All recipients have the following rights:

1. The right to privacy, security, and respect of property.
2. The right to voice a complaint or concern regarding care or service.
3. The right to participate in all aspects of care/services and planning of care/services.
4. The right to refuse all or parts of his/her care to extent permitted by law.
5. The right to have resuscitative services withheld and life-sustaining treatment withdrawn.
6. The right to information about the cost of services that will be billed to his/her insurance(s) and/or self (verbally and in writing).
7. The right to information about the value or purpose of any technical procedure that will be performed, including the benefits, risks, and who will perform the task/procedure.
8. The right to information about ownership or control of the agency.
9. The right to review records.
10. The right to 24-hour crisis intervention.
11. The right to protection from abuse, neglect, retaliation, humiliation, and exploitation. However, **Restore Outreach Center, LLC** reserves the right to include emergency intervention and other special treatment interventions when necessary. When emergency intervention or other treatment interventions are used, **Restore Outreach Center, LLC** assures that they will be administered with consideration given to the physical, developmental, and abuse history of the person served.

IMPORTANT- If at any time a staff member becomes aware of an infringement or violation of a recipient's rights, it is the responsibility of that employee to report that infringement or violation directly to the Clinical Director or the program coordinator as quickly as possible. Furthermore, all such incidents must be documented on a Critical Incident Form immediately.

All recipients have the following responsibilities, unless otherwise stated by the agency upon enrollment:

- The recipient is responsible for attending group meetings in the community and agency.
- The recipient is responsible for allowing agency staff to enter the recipient's home for home visits. Recipients must make reasonable efforts to schedule and meet with agency staff for regular home visits.
- The recipient is responsible for meeting with psychiatrist once a month or as scheduled.
- The recipient is responsible for preparing for transportation during group settings and psychiatrist visits

- The recipient is responsible for signing the Individualized Service Recovery Plan at the start of services and every three months thereafter with the Licensed Mental Health Professional (LMHP) and Psychiatrist.
- The recipient is responsible for obtaining medicine as prescribed by the Psychiatrist.

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- The recipient is responsible for ensuring compliance in taking prescribed medications and reporting side effects on the medications to the Licensed Mental Health Professional/Psychiatrist.
- The recipient is responsible for calling the Licensed Mental Health Professional if moving (change of address/phone number), hospitalized (for any reason), or leaving the local area for an extended period of time to ensure continuity of care.

By signing below, I acknowledge that the staff has explained my *Rights and Responsibilities* as a client of Restore Outreach Center, LLC.

Recipient's Name: _____

Recipient's Signature: _____ _____
Parent/Guardian if recipient is under 18 **Date**

I certify that I have explained the Rights and Responsibilities of Restore Outreach Center

Authorized Representative: _____ Date: _____

Name:
DOB:
Medicaid No.:

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MEMBER GRIEVANCE POLICY

POLICY

Restore Outreach Center acknowledges the dignity of and will protect the rights of all members served as well as their families. This agency will ensure that each member has a freedom of choice with regard to selecting providers of services, including Restore Outreach Center. All participation in Restore Outreach Center's services/programs is voluntary and no member will be forced to receive services for which he or she is eligible.

Restore Outreach Center operates in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended, and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the US Department of Health and Human Services. This means that all individuals are accepted and that all services and facilities (waiting rooms, restrooms, etc.) are available to persons without regard to race, color, religion, age, sex, or national origin.

Each member of our services and/or parent shall have the opportunity to participate in any meeting involving the assessment of needs or the planning of care for that individual.

Except as required by law, no information, written or verbal, concerning the member or his/her family shall be released or requested without a signed, dated, and witnessed statement made by the member, or his/her agent, authorizing Restore Outreach Center to do so. The statement of authorization shall indicate, by name to whom and from whom information will be transmitted and for what purpose.

PROCEDURES

As a member, you have the right to voice a grievance against the manner in which you are treated without fear of reprisals. When doing so, you should follow the appropriate chain of command.

For example, if you have a problem with a staff member working with you or your family.

1. You should first discuss it with that person.
2. If the result is not satisfactory, bring the problem to the attention of their supervisor and/or the Assistant Administrator.
3. If the appropriate individual does not respond within five (5) working days verbally or in writing to your satisfaction, then the complaint should be presented to the Administrator.
4. The Administrator shall respond within five (5) working days.
5. If the resolution is not to your satisfaction, then the complaint shall be presented to the Governing Body, who will hold a meeting with the complainant to produce a decision.
6. If the member is not satisfied with the decision made by the company, the member may exercise their rights to access the final point of resolution.
7. The member may contact Medicaid 1-800-342-6207

Please let us know if you are not happy with Restore Outreach Center, your services, or any decisions that are made about your treatment. You have the right to file a grievance about anything you are not happy with. A grievance can be about anything other than a decision by Restore Outreach Center to deny, limit or change a service that you or your provider requested. This is your right. You do not need to worry that you will be treated poorly for filing a grievance. We want to make sure that you are treated fairly and receive the best service possible. This is one way you can stand up for yourself and your rights. It also helps us make our services better for you and others. You also have a right to appeal. This means you can ask for a review of action taken by Restore Outreach Center or decisions made about what services you get. Call Restore Outreach Center.

Name:
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Phone: 225-223-6968 Fax: 225-442-1396 Email: restoreoutreachcenter@gmail.com

GRIEVANCE ACKNOWLEDGEMENT

When clients of Restore Outreach Center, LLC have a grievance concerning the rehabilitation services that they are receiving, they may request in writing a meeting with the Clinical Manager.

By signing below, I acknowledge I am aware and understand Restore Outreach Center , LLC, Grievance Policy

Client Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

I certify that I have explained all rights and responsibilities to client:

Staff Signature: _____ Date: _____

Name:
DOB:
Medicaid No.:

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Baton Rouge, LA 70809
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Client Abuse and/or Neglect

Criminal statute L.S.A.-R.S.14:403 specifies that any person in the Children's Code who is required to report abuse or neglect, including sexual abuse of a child under age 18, is to report information to authorities when that person has cause to believe a child's physical or mental health or welfare is endangered. Willful and knowing failure to report can result in $500.00 fine or imprisonment for six (6) months, or both.

La. Children's Code Art. 603 defines those persons who must report child abuse as mandatory reporters, which include: any person who provides health care services, e.g., doctors, nurses, technicians; mental health or social services professionals who provide counseling services to a child or his/her family; members of the clergy; teaching or child care providers; law enforcement officers and commercial film processors.

Art. 603 (13) (c) provides an exception to the mandatory reporting requirement for a "Member of the clergy." He is not required to report a confidential communication, i.e., "one made privately and not intended for further disclosure except to the persons present in furtherance of the communication from a person," if the member of the clergy, in the course of the discipline or practice of that church, denomination, or organization, is authorized or accustomed to hearing confidential communications, and under the discipline or tenets of the church, denomination, or organization has a duty to keep such communications confidential. In that instance, the member of the clergy shall encourage that person to report the allegations to the appropriate authorities.

Art. 610 is the reporting procedure that requires mandatory reporters to immediately report to local child protection unit of Department of Social Services in cases where the abuser is believed to be a parent, caretaker, a person who maintains an interpersonal dating or engagement relationship with the parent or caretaker, or a person living in the same residence with the parent or caretaker as spouse whether married or not. If such a person or caretaker is not believed to have any responsibility for the abuse or neglect, the report should be immediately made to the appropriate local or state law enforcement agency. Dual reporting shall be permitted. The initial report may be verbal, and should contain the following information, if known:

1. Name, address, age, sex and race of the child;
2. Nature, extent and cause of child's injuries or endangered condition, including any previous known or suspected abuse to the child or child's siblings;
3. Name and address of parent(s) or caretaker;
4. Names and ages of all other members of child's household;
5. Name and address of the reporter;
6. Account of how child came to reporter's attention;
7. Explanation of cause of child's injury or condition offered by child, the caretaker or any other person;
8. Any other information which the reporter believes might be important or relevant.

If the initial report is verbal, it shall be followed by a written report within five (5) days to the appropriate agency, i.e., local child protection unit or law enforcement agency.
Article 611grants immunity from civil or criminal liability to any reporter, for the making of any report in good faith, and without knowledge of the falsity of such information, or reckless disregard for the truth of the report.

The Directors and staff of Restore Outreach Center, LLC will be responsible for reporting suspected abuse and/or neglect to the appropriate state agencies. Restore Outreach Center, LLC. will follow all state laws in the referral of minor patients to the appropriate child protection agency. All cases will be documented in the client's chart. The telephone number for reporting suspected child abuse or neglect is **1-855-452-5437**

CLIENT or PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____

STAFF SIGNATURE _____ DATE _____

Name:
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24 Hour Crisis/Emergency Availability

After Hours/Crisis Number: 225-924-3900

POLICY: Clients will receive crisis-related services as needed, including during non-regular scheduled office hours and on weekends. Crisis services will be rendered by agency staff on a weekly rotating basis.

PURPOSE: To ensure that emergency needs of clients are addressed in a timely manner.

PROCEDURE:

- All direct service staff and the clinical supervisors will participate in a staff rotating system to provide on-call crisis services. Staff will be on call for one week at a time.
- The rotating system will be run alphabetically (A-Z), per the last name of each staff member.
- The staff member on-call will obtain the agency cell phone for crisis services from the Office manager no later than 4:00 pm of the Friday beginning the week of on-call status.
- Clients will activate the crisis system by calling the After Hours/Crisis Number listed on this form and the client handbook, given to each client at the beginning of services by the client's primary clinician.
- Upon receiving the call from the client in crisis, the on-call staff member must respond within thirty (30) minutes, if a more immediate response is not possible.
- The on-call staff member's role is to assess the nature of the client's status; obtaining as clearly as possible why the client is in a state of crisis.
- Based upon the assessment and the judgment of the on-call staff member, he/she may:
  - Handle the crisis over the phone if possible.
  - Arrange for psychiatric services and possible hospitalization and or direct contact to a Psychiatric facility with which the agency has a prearranged relationship.

All major behavioral and physical health crisis calls must be documented by the worker on a Critical Incident form within 24 hours and on a progress note in Clinical Advisor. Additionally, all crisis calls must be recorded in the Crisis Phone Log which must be handed in to the Clinical Supervisor at the end of the worker's on-call status.

If the on-call worker has difficulty in implementing the policy or determining proper action regarding a client in crisis, the on-call worker must contact the Clinical Supervisor or, if not able to be reached, must immediately call the Crisis Line.

Name:
DOB:
Medicaid No.:

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_____ (DATE)

RE: Release of Information/ Care of Coordination

Client: _____

DOB: _____

Parent/ Guardian: _____

Dear _____ (provider),

_____ has identified you as their provider. In my work with the client, we have discussed the importance of coordinating care across health care professionals. In response to this discussion, the client above has signed an authorization form allowing us to exchange pertinent information with you regarding their care. Please note that Restore Outreach Center (ROC) is behavior health provider, and we are currently providing community-based mental health services to the client. If you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly. I look forward to our working together on an integrated approach for an optimal treatment outcome. Please save this correspondence and the attached consent in your records.

Respectfully,

Krystalyn Cunningham, LPC

Executive Supervisor

Restore Outreach Center, LLC

Baton Rouge- Houma-Marksville

225-223-6968 (Phone) 225-442-1396 (Fax)

Name:
DOB:
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Authorization to Release Recipient Records

Recipient Name:	Social Security#:
Recipient Medicaid #:	DOB:

I hereby authorize: Restore Outreach Center, LLC
4315 Bluebonnet Blvd ste B Baton Rouge, LA 70809
To obtain information from & release information to:

_____
(Name of Health Care Provider holding the information – releasing agency)

_____
(Address) City, ST Zip

The following type(s) of information from my records (and any specific portion thereof):

_____ Record of visit for a specific date or dates. Specific dates include or are limited to: _____
_____ Copies of records or reports provided to the above named (i.e. agency, hospital, lab, clinic, etc)
_____ Photographs, videotapes, digital or other images
_____ Discharge Summary
_____ Social or Mental Health History
_____ Assessments / Evaluations
_____ Consultation Reports
_____ All of the above
_____ Other (Must be specific) _____

_____ **I authorize the disclosure of alcohol or drug information, if any (In accordance**
Initials **with 42 CFR, Part 2).**
_____ **I authorize the disclosure of information, if any, concerning testing for HIV**
Initials **(Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.**

For the Purpose of: Coordination of Care

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that Restore Outreach Center will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.

I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for:

(PLEASE CHECK ONE)

☐ One (1) Year.
☐ The period necessary to complete all transactions on matter related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time by sending written notice of my withdrawal of this authorization to the staff of Restore Outreach Center, LLC.

_____ _____
Signature of Client (if over age 14) Date

_____ _____
Parent/Legally Authorized Representative Date

_____ _____
Signature of Witness Date

Name:
DOB:
Medicaid No.:

Lynn R. Schechter, Ph.D., M.P.

Licensed Medical Psychologist

NOTICE OF INFORMED CONSENT OF MEDICAL PSYCHOLOGY PRACTICE GUIDELINES

IN THE STATE OF LOUISIANA

1. The relationship between Dr. Lynn R. Schechter, Medical Psychologist, and the patient's physician is a collaborative one. Dr. Schechter is required to collaborate and consult with the patient's physician regarding the medication(s) prescribed and managed.
2. In the event a patient does not have a primary or attending physician, Dr. Schechter cannot prescribe for that patient.
3. In the event a patient's primary or attending physician does not concur with the psychopharmacologic treatment planned by Dr. Schechter, Dr. Schechter will defer to the medical judgment of the physician.
4. The client has the right to decline to participate in such a practice and may withdraw at any time without terminating the Medical Psychologist-patient relationship.
5. Dr. Lynn R. Schechter, Medical Psychologist, has the right to withdraw from consultation and collaboration with a specific physician.
6. The client has the right to be notified by written disclosure, of any contractual or financial arrangement that may impact Dr. Schechter's decision to engage in consultation and collaboration with a physician.

_____ _____

Signature of patient or patient's guardian Date

CareSouth
MEDICAL & DENTAL

Authorization For Release Of Protected Health Information (PHI)

This authorizes _____
(Organization) (Individual Releasing information)

_____
(Address)

To release the following information on _____
(Patient's Name) (DOB) (Phone Number)

To/from: **CARESOUTH Medical and Dental**
(Organization) (Individual Receiving Information)

_____
(Mailing Address)

for the purpose of

- [ ] Insurance claim
- [✓] Continued care by another physician or health care Facility
- [ ] Disability determination
- [ ] Marketing
- [ ] Other (please state reason for release)_____
- [ ] Publicity related activities [ ] Fundraising
- [ ] Immunization Records
- [ ] Entire Record [ ] Labs [ ] X-Ray Reports
- [ ] At the request of individual
- [ ] Legal

This authorization will expire in one year or _____.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes?

☐ Yes. Then this is the only item you may request on this authorization. You must submit another authorization for other items below

☑ No. Then you may check as many items below as needed.

✓ Medical Record _____ Itemized bill _____Other_____

Specific description of information to be used or disclosed

_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, and/or genetic test results. _____ (Initial)

I hereby consent to release my HIV test results: _____ (Initial) I have a right to refuse to release my HIV test results, except where release is authorized by law without my consent.

I understand that :

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the receiver is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may have a copy of this form after I sign it. I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian:_____ Date:_____

NOTICE OF CONFIDENTIALITY

The information contained in this facsimile transmission is confidential information and may be legally privileged or protected work product under applicable law. The information is intended solely for the use of individual or entity name above. If you are not the name recipient, you are hereby notified that you have received this transmission in error and that any review, disclosure, copying dissemination, or taking of any action in reliance on any information contained in this facsimile transmission is forbidden by the sender and may be illegal.

Should you have any trouble in receiving this facsimile or have not received all pages of this transmission, please notify us immediately at the above telephone number.

Lynn R. Schechter, PhD, MP

Amended guidelines for provision of Telehealth services during COVID-19

per Louisiana Department of Health

Effective 8/1/20

- Due to the state and local recommendations and mandates in response to COVID-19, behavioral health services will be conducted through telehealth.

- Clinical services are still provided with strict confidentiality through HIPAA secure platorm (DOXY.me) BH Counselor is present in a private location.

- The patient is aware of risks of telehealth and options to respond to an emergency during the session; privacy risks if session is hacked; and hardware or software malfunctions and the session is disconnected suddenly.

- The benefits of telehealth including minimizing exposure to COVID-19 by maintaining distance and not requiring the client to leave the house to receive counseling services.

- Other alternatives to telehealth including seeking a provider providing services face to face or delaying service provision until face to face services are offered. These alternatives will minimize risk of privacy or software concerns but increase risk of exposure to COVID-19.

- The risks of no treatment including exacerbation of mental health symptoms and benefits of no treatment including mental health symptoms improving spontaneously.

- Audiovisual telehealth services are available but if telehealth loses internet connection, telephonic service will be used to conduct session.

- Clinician requested additional contact numbers to restart session if software malfunctions. Counselor requested emergency contact name and number that can be reached in event of Client crisis. Client
- Clinician advised the client in the case of an emergency or a crisis to call 911 or proceed to the closest emergency room. Suicide hotline number (1-800-273-8255) provided.
-

Patient name/signature Date

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INFORMED CONSENT FOR RECEIVING TELEBEHAVIORAL HEALTH SERVICES

Teletherapy, or telebehavioral health services, by definition, is the delivery of ROC services by which the advocate/counselor and client are not within the same physical location. This includes, but is not limited to, webcam sessions, telephone conversations, e-mails, text messages, or any communication involving the Internet as a medium. All telebehavioral health services are conducted within the State of Louisiana and are governed by the laws of that state. Any telebehavioral health services conducted must be within the physical boundaries of Louisiana. It is the responsibility of you, the client, to inform if this is not the case, in which telebehavioral health services will be suspended. Telebehavioral health sessions are conducted via telephone or a HIPAA-compliant videoconferencing software, that provides encryption, and protects client's data. Your worker(s) will provide instructions on how to access this.

CLIENT NAME: _____ **TODAY'S DATE:** _____

I understand that I have the following rights with respect to receiving online services from ROC:

- I understand that the laws that protect my confidentiality in the office, also apply to online services. As such, I understand that the information disclosed by me during my services at ROC is confidential. However, there are exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse, and expressed threats of violence to myself or towards someone else.
- I understand and accept that emergency services are not included in telebehavioral health services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, I can contact the National Suicide Prevention Lifeline at: 1-800-273-8255.
- I understand that telebehavioral health services may not be as complete as face-to-face services. I also understand that if the worker believes telebehavioral health services are not in my best interest, he or she will explain that to me and suggest some alternative options better suited to my needs, until face-to-face sessions can resume.
- I understand that I waive any confidentiality protections if I am in a public space or have others present near me while using teletherapy services. In the event that I use my own phone, tablet, computer, laptop etc. I also waive confidentiality protections if others have or gain access to either of those items.
- I understand there are risks and consequences from engaging in telebehavioral health services with ROC, including, but not limited to, the possibility, despite reasonable efforts on the part of my worker, that:
  - the transmission of my information could be disrupted or distorted by technical failures;
  - the transmission of my information could be interrupted by unauthorized persons;
  - and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- My ROC clinician will explain how the Telebehavioral health service is performed and how it will be used for my treatment. My ROC clinician will also explain how the service(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology. I understand that it is my duty to inform my ROC clinician of electronic interactions regarding my care that I may have with other health care providers.
- If during the course of my Telebehavioral health session I am unable to complete the session for any reason, I will immediately notify ROC staff. Every attempt will be made to preserve my scheduled appointment. However, if I am unable to complete the service, ROC will reschedule my appointment as soon as possible with an available ROC clinician.
- I understand that I have the ability to withdraw consent to telebehavioral health services at any time.

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INFORMED CONSENT FOR TELEBEHAVIORAL HEALTH SERVICES

I have read this document and understand the benefits and risks of participating in telebehavioral health services, and I have had my questions regarding this process explained.

_____ (initials) I consent to participate in telebehavioral health online services under the conditions described in this document.

_____ (initials) I do not consent to participate in telebehavioral health services and understand that I will not have consistent contact with my advocate or counselor until face-to-face sessions resume. If I need support or become triggered during this time, I can call National Suicide Prevention Lifeline at 1-800-273-8255 or text the word HOME to 741741. I can also report to the nearest emergency room if I experience any suicidal and or homicidal ideations.

_____ _____ Client Signature/ Date

_____ _____ Parent/Guardian Signature (IF applicable)/ Date

_____ _____ Staff Signature/ Date

Name:
DOB:
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Client Accessibility Form for TeleBehavioral Health Services

Client Name: _____ Phone #:_____

Purpose: Due to the concern about the Coronavirus (COVID-19) and its impact it may have on our staff and clients, we are contacting our clients to assess their comfort level and ability to participate in sessions over the phone or video chat.

Does the client have the following?

Yes	No	
		Phone
		Computer, laptop, or tablet with a camera and microphone
		Internet access
		Enclosed, private space to participate in session remotely
		Email address

In the situation where we are only able to provide remote services, is the client interested in the following?

Yes	No	
		Conducting sessions over the phone
		Conducting video sessions using computer, laptop, or tablet
		Suspending services until in-person services are available

Best way to contact client as information about next steps develop:

___ Phone call; what is the best #: _____

___ Text message; what is the best #: _____

___ Email; what is the best email: _____

Additional notes:

_____ _____ Client Signature/ Date

_____ _____ Parent/Guardian Signature (IF applicable)/ Date

_____ _____ Staff Signature/ Date

Name:
DOB:
Medicaid No.: