AMANA HEALTHCARE SERVICES, LLC
16100 Cairnway Dr. Ste. 210, Houston TX 77084
Ph: 281-836-3090 email: info@amanahealthc.com

Initial Client Intake:

Date of Referral: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

D.O.B: _____ SSN#: _____ Contact #: _____ Email: _____

Male _____ Female _____ Medicaid #: _____ Insurance type: _____

Guardian/Parent name: _____Contact #: _____

Email: _____

Presenting Problem: _____

Have you ever received mental health or substance abuse service before? Yes _____ No _____

If "Yes" Where? _____

When? _____ Are you on medication? Yes _____ No _____

If "Yes" List Meds: _____

What type of service are you requesting: _____

Referral Source: _____ Contact #: _____

Email: _____ Fax #: _____

I do understand this form is only a referral to receive services from Amana Healthcare Service LLC and it does not guarantee enrollment into the program.

Client Signature: _____ Date: _____

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Emergency Contact

1. Emergency Contact Name: _____
   Ph. # _____
   Relationship to Consumer _____
2. Emergency Contact Name: _____
   Ph. # _____
   Relationship to Consumer _____

Medical or Health Emergency Consent

I consent to the administration of emergency medical procedures and treatment by qualified staff of this agency (First Aid/CPR). In case of an emergency, I agree to be transported to the nearest appropriate medical facility and to assume all cost for transportation and treatment.

In the event emergency medical aid/treatment is required due to illness or injury during the process of participating in services, Amana Health services to:

1. Secure and retain medical treatment and transportation if needed
2. Release consumer records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedures deemed “life-saving” by the physician. This provision will truly only be invoked if the person(s) above is unable to be reached.

Family Physician Office: _____

Phone#: _____

Office Name _____

Address: _____

Hospital Preference: _____

Phone#: _____

Consumer Signature: _____ Date _____

Parent/Guardian Signature: _____ Date _____

AHS Staff Signature: _____ Date _____

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CONSENT FOR SERVICES, EMERGENCY TREATMENT AND CLIENT CHOICE

I do hereby seek and consent to take part in treatment with Amana Healthcare Services LLC. I apply for, and consent to participate in, such Behavioral health and Targeted Case management services, crisis, evaluation and treatment services as are approved and recommended by the physician (or other appropriate staff) of Amana Healthcare Services. I understand that developing a treatment plan, regularly reviewing my progress toward meeting the treatment goals and regular participation in appointments are in my best interest. I agree to play an active role in this process.

I understand that I will be receiving the following services provided by AMANA HEALTHCARE SERVICES, LLC: ☐ Assessment/ Reassessment ☐ Skills Development and Training ☐ Individual /Family Intervention Counseling ☐ Other_____ ☐ Medication Training and Support ☐ Intensive Case Management ☐ Group ☐ Other _____

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Amana Healthcare Services LLC.

I acknowledge that I have been given the opportunity to have all my questions answered fully.

I understand that if I have any questions regarding the Consent for Treatment Form; I can contact Amana Healthcare Services.

By signing this document, I am stating that I have read and agree to the following conditions regarding services rendered by Amana Healthcare Services LLC.

_____ _____
Consumer Signature Date

_____ _____
Parent / Guardian Signature Date

_____ _____
AHS Staff Signature Date

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ADDITIONAL CONSENTS

_____ CONSUMER RIGHTS & RESPONSIBILITIES

I hereby acknowledge that I have received and have been given a copy of Amana Healthcare Services' Consumer Rights & Responsibilities. I understand that if I have any questions regarding the Consumer Rights & Responsibilities; I can contact Amana Healthcare Services LLC.

_____ 24/7 ON-CALL SERVICE ACCESSIBILITY & CRISIS SERVICES

Amana Healthcare Services is dedicated to providing the best care for our consumers. Our services are available 24 hours a day, 7 days a week, through on-call arrangements with our team members. A timely response will be available when a family requires face to face crisis intervention. Our team is always available to assist the consumer and his/her family in case of a crisis situation. All consumers need to call 911 first when there is a threat of violence, suicidal/homicidal gestures, or aggression. Amana Healthcare Service can be contacted secondary for support. Crisis calls are accepted 24 hours a day, and 7 days a week. If a crisis occurs after normal business hours or Holidays, and Weekends and you cannot directly contact one of your Amana Healthcare Service Team Members, please call MMCOC 713-907-3800.

_____ PSYCHIATRIC AND PSYCHOLOGICAL SERVICE AVAILABILITY

For those families who require it, Amana Healthcare Services has access to psychiatric and psychological services, as provided by a Psychiatrist or a Licensed Psychologist.

_____ SECLUSION AND RESTRAINT POLICY

It is the policy of Amana Healthcare Services, not to utilize any seclusion or restraint techniques with any consumer under any circumstances.

_____ INTERVENTION/STRATEGIES

I agree to allow Amana Healthcare Service employees to implement professionally accepted methods of intervention and therapeutic strategies as indicated by the comprehensive person-centered treatment plan that both the consumer/legally responsible representative and the service providers have developed.

_____ CONSENT TO TRANSPORTATION

I, consent to Transportation by Amana Healthcare Service staff and agree to hold Amana Healthcare Service and its staff members harmless from any liability that results from the provision for transportation. I also consent to emergency medical treatment in the event that I am unable to provide such consent in an emergency.

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ADDITIONAL CONSENTS:

_____ GRIEVANCES/COMPLAINT POLICY

I hereby acknowledge that I have received and have been given a copy of Amana Healthcare Services Grievances/Complaint Policy. I understand that if I have any questions regarding the Grievances/Complaint Policy form, I can contact Amana Healthcare Service at

_____ CONSENT TO PARTICIPATE IN ACTIVITIES

I authorize the above-mentioned individual to participate in activities (i.e. swimming, field trips, bowling, etc.). I will inform Amana Healthcare Service of any activities that the individual will not be able to participate in.

FAMILY INVOLVEMENT CONSENT/DENIAL

_____ I consent to have the family members listed below involved in the planning and delivery of the services that I shall be receiving from Amana Healthcare Service for this period of service. I understand that, without this consent, the agency's employees will not be allowed even to acknowledge to any family member that I am a consumer of their services.

_____ I do not consent to have family members involved in the planning or delivery of the services I shall be receiving in this period of services

Family members to be involved:

Name _____

Relationship _____

Ph# _____

Name _____

Relationship _____

Ph# _____

_____ EMERGENCY CONTACT

I have received a copy of the Emergency Contact Sheet that provides me with information on how to get assistance in case of an emergency during the day or after hours.

_____ ADVANCE DIRECTIVES

I have received a copy of the brochure/questionnaire on Advance Directive. I understand if I choose to participate, I will notify my primary care provider and submit a copy of my decision to be filed in my service record.

Consumer Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

AHS Staff Signature _____ Date _____

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Authorization for Release of Information

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, and to coordinate treatment services

I HEREBY REQUEST AND AUTHORIZE: Amana Healthcare Service

☐ OBTAIN RECORDS FROM ☐ RELEASE RECORDS TO

Name/Agency _____

Address _____

Phone/Fax _____

To disclose the following specific information:

☐ Psychiatric Evaluation ☐ Psychological Reports ☐ Medical Records
☐ Psychosocial History ☐ Treatment Plan ☐ Labs (Drug Screens, etc.)
☐ Case Records/Reports ☐ Discharge ☐ Progress in Treatment
☐ Other: _____

I understand that this information will be used for:

☐ Screening/Referral ☐ Progress Notes ☐ Referral Information
☐ Billing/Payment Purpose/ Insurance Eligibility/ Collections
☐ Other: _____

My signature below indicates that I have read and understand this consent/choice form.

_____ _____
Consumer Signature Date

_____ _____
Parent / Guardian Signature Date

_____ _____
AHS Staff Signature Date

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Notice of Privacy Practices /Receipt and Acknowledgment of Notice.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Verbal Permission

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at [PO Box 1051, Roseboro NC 28382]:

- **Right of Access to Inspect and Copy.**
- **Right to Amend.**
- **Right to an Accounting of Disclosures.**
- **Right to Request Restrictions.**
- **Right to Request Confidential Communication.**

ACKNOWLEDGEMENT

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Amana Healthcare Service Notice of Privacy Practices handbook.

Consumer Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

AHS Staff Signature _____ Date _____

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SAFETY PLAN AGREEMENT

In the event in which the safety of a member of a family that we service is compromised; a safety plan is the most effective means of addressing and ensuring that any crisis is rendered nonexistent or minimized. To ensure that you and your family are always safe, we request that you agree to the following terms:

As a volunteer participant in services, I, _____, agree to disclose possession of any weapons or feelings of suicide to the members of the respective clinical team that is working with me and my family. I also agree not to use any item that can inflict injury to me or any member of my family. If the situation arises when my frustration is to the point that I want to physically harm myself or someone else, I will contact a member of the clinical team to process the occurrence in a therapeutic and non-threatening manner.

If the situation is violent in nature or defined as an emergency, I will immediately contact the local authorities by dialing 911 (If applicable). I will also contact a family member or family friend, _____, at _____ as an additional resource to assist. I, or members from the clinical team that is working with me and my family, may also contact my caseworker, probation officer, or the referral source to inform them of any violent/suicidal occurrences or threats/expressions of violence/suicidal occurrences. Upon informing the clinical team members of possible violent/suicidal thoughts, and it is deemed that I present to be a danger to myself or others, I understand that they have the ethical and clinical obligation to contact the proper authorities.

Are there any specific additions that need to be made to this agreement? Yes___ No___
If yes, use the provided space below to specify details. If no, proceeds to signatures section.

_____

_____

_____

Consumer Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

AHS Staff Signature _____ Date _____

This is a strictly confidential patient medical record.

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Abuse/Neglect Protocol/Procedure

It is your right to be free of harm, abuse, neglect and exploitation. Amana Healthcare Services, LLC prohibits any abuse or neglectful conduct on the part of any individual employed or contracted by the agency or serving in a consultative capacity. If for any reason, you have questions, concerns or complaints that involve any kind of abuse, sexual, physical etc. you should call the Texas Department of Family and Protective Service at 1-800-252-5400.

Consumer Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

AHS Staff Signature _____ Date _____