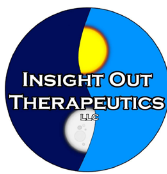

Demographic Information

First Name:______________________________Last Name:_________________________ Preferred Name:___________________

Address:____City:__________________________State:_____

Zip:_____________________County:__________________SS#: ___________________ Date of Birth:______________ Age:______

Phone #:__________________ May we leave a message ______________ Email:______________________________________

Cell phone #:_____________ May we leave a message ______________ Can you receive text notifications __________

Race: ____________ Gender Identification ____________________________ Preferred Pronouns______________________________

Legal Guardian: ____Phone #:______________________________

Relationship to Client: ____

Emergency Contact:____Phone #: ______________________________

FINANCIALLY RESPONSIBLE PARTY/INSURED (if other than patient):

Last Name: _______________________________ First Name:___________________________ M.I. ___ Date of Birth:____________

Address: ____ City:_____________________________ State:_____ Zip:____________

Home Phone:_____________ Cell Phone:_______________ Work Phone:_______________ Email:_____________________________

Employer:____ Occupation: ________________________________

INSURANCE INFORMATION:

Primary:____Policy #:______________________Group: ___________

Address:____City, State, Zip: _______________________________________

Phone Number: _______________________________

Secondary:____Policy #: ____________________Group:___________

Address:____City, State, Zip: _______________________________________

Phone Number: ______________________________

I give my permission for the following people to gain access and have knowledge regarding my (or my child's) treatment with Insight Out Therapeutics, LLC.

____________________________________ ___________________________________ _________________________________

****

I authorize the provider of services to release all information necessary to secure payment of benefits to carry out a reasonable level of treatment. I directly assign all medical benefits from my insurance to the provider, if applicable. As a courtesy to you, we may choose to bill your insurance. I agree to abide by the attached Financial Statement of Understanding and, if applicable, by the limits defined in the attached informed consent and minor client informed consents. If I have Medicaid as my insurance, I hereby agree that I have been given a freedom of choice of my treatment provider.

Signature of Responsible Party: ____ **Date:** ____________________

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Financial Agreement

Client Name:_________________________________ Date of Birth:______________

Name of Person Financially Responsible:______________________________ Relation to Patient:__________

By signing below, you are acknowledging that you have read, understood, and agree to the following financial policies of Insight Out Therapeutics and your individual therapist. This agreement is to serve as a legally binding financial agreement between the client named above, his/her/their financial proxy (as named above), and Insight Out Therapeutics. You further acknowledge that unless otherwise specified by *written* agreement, this policy will supersede all previous signed agreements.

Payment for Services:

- **Insurance:**
  - Currently, we offer the ability to utilize your commercial insurance and Medicaid benefits to cover the cost of our services. Upon our contact with your insurance company, they may dictate that you are responsible for a portion of your benefit (a copay, co-insurance, member responsibility, etc). We will affirm coverage at the beginning of the calendar year; when you begin services with us; and/or when you inform us of a change to your coverage.
    - Any questions or issues of cost to you must be made between you and your insurance company as we are acting in good faith based on the information provided by your carrier in our verification of benefits.
  - Any cost sharing that your insurance carrier shows as your responsibility is expected to be paid ***prior*** to services being rendered. **At this time we accept all major credit/debit/HSA/FSA cards, checks, cash, or money orders.**
- **Self-Pay Clients:**
  - Our therapists and interns charge fees at variable rates. The cost per session is based on a 53-minute therapeutic hour. It is your and your therapist's discretion to go over or under that amount of time. Any fraction of that time will be prorated to the amount of time that the session went over/under. The time frames are as follows:
    - 0-37 minutes = 50% of the hourly fee
    - 38-52 minutes = 75% of the hourly fee
    - 53-60 minutes = 100% of the hourly fee
  - Your payment is expected to be paid prior to services being rendered. **At this time we accept all major credit/debit/ HSA/FSA cards, checks, cash, or money orders.**
- **Extraneous Charges:**
  - Your therapist reserves the right to charge his/her session rate under the following circumstances: returning phone calls to clients and their attorneys, completing affidavits, writing letters on behalf of clients, etc.
  - If asked to appear in court on your behalf, The charges are as follows:
    - $325.00/hour. Billable hours are to start as soon as the therapist begins to prepare for his/her testimony to include, case review, travel (to accrue from the point of clinician departure), waiting to be called to testify, and testimony. Fees will continue to accrue until the clinician is excused by the court and his/her testimony is concluded plus return travel time.
    - A five (5) hour retainer ($1625.00) is due prior to any preparation for testimony and all billable hours will be deducted from that amount. In the event of overpayment, a refund will be issued within 48 business hours *after* the clinician is excused from his/her testimony by the court. In the event of underpayment, an invoice will be forwarded to you within 48 business hours after the clinician is excused from his/her testimony by the court. Any balance that is not paid for more than 45 days from the date of service will result in your account being submitted to a professional collection agency unless payment arrangements have been made, and the client may be administratively discharged from our services and referred to another clinician outside of the agency.
- **New Clients:**
  - New clients to our practice will be asked to place a credit card on file. The card will not be charged until the start of your session, where you will also have the ability to change payment methods.
  - You will be required to submit all the paperwork along with a credit card authorization form 72 hours prior to your first appointment. If it is not returned within that time frame your appointment will be canceled and your card will not be charged.
  - Should you not show up for your first appointment, or be more than 20 minutes late **for any reason**, your card will be charged $75.00 for the missed session and you will be afforded an opportunity to reschedule the appointment.
- **Appointment Reminders:**
  - Our system sends out automated appointment reminders. We have no control over when the reminders are sent. The reminder schedule is as follows:
    - Cell phone reminders:
      - When an appointment is made, changed, or canceled
      - 50, 26, 4, and 2 hours prior to the start of the appointment time.
    - Email Reminders:
      - When an appointment is made, changed, or canceled
      - 50, 26, and 2 hours prior to the start of the appointment time.

Client Name:_________________________________ Date of Birth:_____________

Name of Person Financially Responsible:_____________________________ Relation to Patient:_________

- **Invoicing:**
  - Clients who have been seen in the office for at least 90 days may be offered the privilege of invoicing their fees. In order to be considered for invoicing, the client must have an account in good standing, must not have more than two (2) missed sessions outside the 24 hour cancellation window, and must have at least one (1) future-scheduled appointment.
- **Cancellations:**
  - Cancellations must be made no less than 24 ***business*** hours prior to the start of the appointment time. Monday appointments need to be canceled no later than close of business on Friday. To cancel an appointment scheduled on the day after a holiday, it needs to be canceled on the day prior to the holiday. Appointments may be canceled by calling out office and leaving a message, or emailing scheduling@insightouttherapeutics.com (it is preferable to email as you then have a record of your cancellation).
  - In the event that you miss an appointment without giving any notice at all, or with a less than 24 hours' notice, you will be charged a fee of $75.00, which must be paid prior to the beginning of your next session.
    - Your clinician has the final decision to waive this charge at the rate of one (1) time per quarter. This is applied at the ***sole discretion*** of your clinician.
    - Missing an appointment without proper notice may also result in the cancellation of future standing appointments. This is applied at the ***sole discretion*** of your clinician.
  - Failure to properly advise us a total of two (2) times for a session you will miss will be considered client initiated termination at which time you will receive a letter to advise you of other counseling services in your area.
  - As the therapeutic hour is important to have in full, should you be more than 20 minutes late for your session, your session will be canceled and a cancellation fee may be assessed at a cost of $75.00. Waiver of this fee is applied at the sole discretion of your clinician.
  - It is imperative that our clinicians have the full allotted time to assist you with your needs. Sometimes the unavoidable happens that impacts the timeliness of the clinician or the client. We offer a 20 minute grace period to all of our clients. Once that amount has passed, we will have to reschedule your appointment, and you will incur the same missed session fee as you would for a untimely cancellation - a fee of $75.00.
- **Standing Appointments:**
  - Currently, we allow a client to have at least 2 future appointments on the schedule at one time. Any deviation of the number and frequency of those future-scheduled appointments is also at the sole discretion of your therapist.

By signing below, you are acknowledging that you have read, understood, and agree to the following financial policies of Insight Out Therapeutics and your individual therapist. This agreement is to serve as a legally binding financial agreement between the client named above, his/her/their financial proxy (as named above), and Insight Out Therapeutics. You further acknowledge that unless otherwise specified by written agreement, this policy will supersede all previous signed agreements.

____ _____________________

Client Signature Date

____ _____________________

Responsible Party Signature Date

____ _____________________

Administrator Signature Date

Rev 05/21

Client Name:____ **DOB:**_________________________

INFORMED CONSENT FOR TREATMENT

We are pleased that you have selected Insight Out Therapeutics, LLC. to work with you. This letter serves to inform you about the therapeutic treatment process, give you some information and answer questions about the professional relationship between therapist, patients, and their families. We have a number of client expectations about the professional relationship we embark on with each client.

CONFIDENTIALITY: Confidentiality is an important part of the mental health/ addictive disease treatment/therapy process. It means that unless you give us written permission, we may not give any information about you to anyone outside of Insight Out Therapeutics, If you and another adult (someone 18 years of age or older) are seen together, BOTH of you must agree in writing before any information can be released. There are specific times; however, when the law requires us to give information about you with or without your consent:

1. To report known or suspected instances of abuse, exploitation, or neglect of children and elders.
2. When you are a danger to your own life.
3. When you have made a credible threat to the life of another.

RISKS and BENEFITS of THERAPY: While mental health/addictive disease therapy can be an effective mode of treatment for a variety of life problems, positive results cannot be guaranteed. One major benefit that can be gained from participating in treatment/therapy includes a better ability to handle or cope with family and other interpersonal relationships. Other benefits relate to the potential to resolve specific concerns brought to treatment/therapy. Seeking to resolve issues between family members and other person can similarly lead to discomfort, frustration and relationship changes not originally intended. Insight Out Therapeutics, LLC. clinicians focus on the relational nature of therapeutic problems. At any time, you may ask your clinician(s) to explain more about how they work, why they are gathering information, or why they are prescribing a particular approach.

EMERGENCY PROCEDURES: If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department. You can call the Georgia Crisis and Access Line for any mental health emergency 1-800-715-4225.

COMPLAINT RESOLUTION PROCEDURES

The staff of Insight Out Therapeutics, LLC. wants to know that you are satisfied with your individualized program. We also understand that with any ongoing relationship, there may be times of conflict. It is important to all of us that you feel your complaints or concerns are heard. The following is a guideline and time-frame for filing complaints. The first person to call should you have any problem with program staff is your therapist. You should expect to have he/she help me resolve the conflict within two (2) business days. Again, we believe that in working together to address conflict and concerns can only serve to help you reach your goals in your treatment plan through the services that are provided by Insight Out Therapeutics, LLC. Should my therapist not be able to resolve your concerns, please contact our Clinical Administrator at 470-215-6101.

MANDATED REPORTING STATEMENT

As required by our regulatory agencies, the following information is provided:

1. Insight Out Therapeutics does not support nor condone the use of corporal punishment at any time.

2. Under state law, all supervisors, therapists, interns, and employees of Insight Out Therapeutics are mandated reporters of child and elderly abuse and neglect. That is, we are required to make a report to the appropriate county office of the Department of Family and Children Services or related department when there is reasonable cause to believe that an elderly person or a child under the age of 18 years old has had physical injury inflicted upon him or her by a parent/caretaker by other than accidental means, has been neglected or exploited by a parent/caretaker or has been sexually assaulted or sexually exploited.

Please Read and Sign Below:

- I have read and understand the above statement concerning the limits of confidentiality, the risks and benefits of therapy, payment and cancellation policy, and emergency procedures. I do hereby seek and consent to take part in treatment provided by Insight Out Therapeutics, I understand that if payment for the services I receive is not made, the clinician may stop treatment. My signature below indicates my informed consent to receive services and reflects that I understand and agree with all of the above statements. I have been given the opportunity to ask questions regarding this information.
- I understand that the fees for services are payable at the time of service. I understand that I am financially responsible for all charges whether reimbursed to me by insurance or not.
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged the session fee for that appointment.
- I acknowledge I have received a copy of Client Rights & Responsibilities, received an orientation of services, and give my voluntary consent for treatment.
- I acknowledge I have received the Notice of Policies and Practices to Protect the Privacy of Your Health Information. I acknowledge that I was provided a copy of the “Notice of Insight Out Therapeutics' Policies and Practices to Protect the Privacy of your Health Information” and that I have read (or had the opportunity to read if I so choose again).
- Informed Consent: By affixing my signature to this form, I acknowledge that I have read, understood, and agreed to all of the polices detailed above and in the *Notice of Insight Out Therapeutics' Policies and Practices to Protect the Privacy of your Health Information*. I consent for my therapist to disclose PHI to my insurance company or PCP if required for paymentof claims.

A staff member of Insight Out Therapeutics has reviewed the forms with me and I have received a copy of each form. I have had the opportunity to ask questions regarding these forms/ policies.

Client Signature: ____Date: ____________________

Parent/Legal Guardian Signature:______________________________________Date:____________________

CLIENT COPY

Client Rights

In compliance with Insight Out Therapeutics' policies, and procedures, all clients have the following rights:

1. Right to a humane treatment or habilitation environment that affords reasonable protection from harm, exploitation, and coercion;
2. Right to be free from physical and verbal abuse;
3. Right to be free from the use of physical restraints and seclusion;
4. Right to be informed about plan of treatment and to participate in the planning, as able, to include development of the plan, review of the plan, and notification of changes made to the plan; Right to be involved in the transition and discharge planning process;
5. Right to be promptly and fully informed of any changes in the plan of treatment;
6. Right to accept or refuse treatment, unless it is determined through established authorized legal processes that the client is un-able to care for himself or is dangerous to himself;
7. Right to be fully informed of the charges for treatment;
8. Right to confidentiality of client records;
9. Right to have and retain personal property which does not jeopardize the safety of the client or other clients or staff and have such property treated with respect;
10. Right to converse privately, have convenient and reasonable access to the telephone and mails, and to see visitors, unless denial is necessary for treatment and the reasons are documented in the client's treatment plan;
11. Confidentiality of information rights;
12. Privacy rights;
13. Freedom from abuse, financial or other exploitation, retaliation, humiliation, and neglect
14. Access to information pertinent to the client in sufficient time to facilitate client decision making;
15. Informed consent or refusal or expression of choice regarding: service delivery, release of information, concurrent services, composition of the service delivery team, involvement in research projects, if applicable;
16. Access or referral to legal entities for appropriate representation at the client's expense
17. Access and referral to self-help/ advocacy support services
18. Adherence to research guidelines and ethics when a client is involved, if applicable
19. Right to be free of physical holds (emergency intervention), seclusion, or restraint;
20. Right to be involved in treatment planning, review of the plan, and notification of changes to the plan;
21. Right to be able to access the client's own records and obtain necessary copies when needed; right to request in writing a review of the client's own file and receive a response within 30 days; Insight Out Therapeutics, Inc. shall make the determination using up-to-date HIPAA guidelines.
22. Right to be informed of all rights, including legal rights, and exercise rights without reprisal in any form, including continued, uncompromised access to services. Rights should be distinguished from privileges, which may be revoked or revised at any time. Clients may follow the grievance procedure to appeal restrictions placed on privileges. Insight Out Therapeutics, LLC. shall review these grievances in accordance with the grievance procedure. Right to file grievances without fear of reprisal; Investigation and resolution of alleged infringement of rights;

Client Responsibilities

1. All clients/guardians have the responsibility to participate in the planning of their treatment.
2. All clients/guardians have the responsibility to be honest about matters that relate to their treatment.
3. All clients have the responsibility to be respectful of the rights and dignity of other clients, as well as staff.
4. All clients have the responsibility to respect the confidentiality of others in treatment.
5. All clients, upon decision to participate, have the responsibility to support and respect the program at the facility by participating to the best of their ability and by being on time for scheduled appointments.
6. All clients/guardians have the responsibility to learn and comply with the rules of the program.
7. All clients/guardians have the responsibility to meet whatever financial obligations may be incurred as it relates to their treatment.
8. All clients/guardians have the responsibility to advise the provider of services of any changes in the client's condition or any events that affect the client's service needs.
9. All clients/guardians have the responsibility of notifying the front office and administrative staff of any changes in their insurance benefits.
10. All clients/guardians have the responsibility of asking questions about their treatment and for seeking clarification until they fully understand the care they are to receive.
11. All clients/guardians have the responsibility for expressing their opinions, concerns, or complaints to the appropriate personnel in a constructive manner.

Notice of Insight Out Therapeutics' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - — Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
  - — Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - — Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are the use of electronic health records, email, texting, electronic billing, tele-mental-health services, quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also obtain authorization from you before using or disclosing PHI in a way that is not described in this Notice. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse — If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.
- Adult and Domestic Abuse — If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.
- Health Oversight Activities — If we are the subject of an inquiry by the Georgia Composite Board, Georgia Board of Psychological Examiners, or other applicable Georgia Board, we may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings—If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety — If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- Worker's Compensation — we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- Exceptions- When the use and disclosure without your consent or authorization is allowed under other sections ofSection 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease of FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Therapist's Duties

<u>Patient's Rights:</u>

- *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.
- *Right to Amend*— You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.
- *Right to a Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*- You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI*- You have a right to be notified if: (a) there is a breach (a use of disclosure of your PHI in violation of the HIPPA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessments fails to determine that there is a low probability that your PHI has been compromised.

<u>Therapist's Duties:</u>

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to modify the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. In the event of a modification, we will provide you with a revised notice by mail or bya posting in the waiting room, which you will see on your next visit.

V. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Chuck Lenahan. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services and we can provide you with the appropriate address upon request.

VI. Cancellation Policy

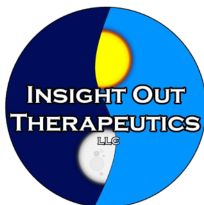
In the Event of an emergency, you will not be charged for session cancellation. Cancellation for any other reasons that are not received by center staff at least 24 hours prior to the scheduled session will be billed at the usual session hourly rate. Monday appointments need to be canceled by noon on Friday. To cancel an appointment scheduled on that day after a holiday, it needs to be canceled on the day prior to the holiday. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility

Insight Out Therapeutics will assist you in completing and filing any insurance forms which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. Insight Out Therapeutics does accept payment by cash, check, or credit card.

IX. Protected Health Information

Your therapist may be required by your insurance company to disclose your protected health information (PHI), and some insurance companies require coordination of care with your Primary Care Provider (PCP).



Acknowledgment of Personal Health Information (PHI)

I have read the *Insight Out Therapeutics' Policies and Practices to Protect the Privacy of Your Health Information*, and I both understand and approve of its content. I also have been offered a copy of the policy.

____ ____________________________

Printed Name of Client Witness

____ ____________________________

Signature of Client and /or Guardian Date

By signing below, I acknowledge that I have read and fully understand my rights and responsibilities as a client at Insight Out Therapeutics, LLC.

Client Name (Printed): ____

Client Signature: ____ Date: ____________

Guardian Name (Printed): ____

Guardian Signature: ____ Date: ____________

Client Orientation for Services Acknowledgement

Name:____ Date:________________

The following information has been explained to me & I have had an opportunity to ask questions.

- Explanation of Client Rights and Responsibilities
- Explanation of Expected Benefits of Treatment
- Explanation of Compliant and Appeal Procedures
- Explanation of ways in which input can be given (open-door policy, suggestion box, surveys, etc.)
- Confidentiality Policies
- Intent/Consent to Treatment
- Behavioral Expectations of the Person Served
- Transition Criteria & Procedures
- Discharge Criteria & Plan
- Response to Identification of Potential Risk to the Person Served
- Access to After-Hours Services
- Standards of Professional Conduct related to services
- Requirements for reporting and/or follow up for the mandated person served, regardless of his or her discharge outcome.
- Any and All Financial Obligations, Fees, and Financial Arrangements for services
- Explanation of Insight Out Therapeutics' Health & Safety Policy- Including: the use of seclusion or restraint, use of tobacco products, illegal or legal substance brought into the program, prescription medication brought into the program, weapons brought into the program
- Explanation of Insight Out Therapeutics' Program Rules & Expectations – including restrictions on the person served, events, behaviors, and attitudes that will not be tolerated along with the consequences for such behavior, means by which a client may regain rights or privileges that have been restricted
- Client is familiar with the premises, including emergency exits, fire suppression equipment and first aid kits
- Client has been educated on Advanced Directives (if desired).
- Client has been educated on the process and purpose of the assessment
- Client understands the process of individualized treatment planning (i.e., how it will be developed) and how he or she will be expected to participate in the goal development and achievement, potential course of treatment/services, how motivational incentives may be used, expectations for legally required appointments, sanctions, or court notifications, expectations for family involvement, and process and consequences of non-adherence
- Identification of the person(s) responsible for service coordination and treatment provider
- Explanation of the potential for legal action, sanctions or court notifications
- Client has been given the name and contact information for the members of their treatment team
- Client has been given a chance to ask questions and have them answered in a way that is understandable to them.
- Client has been given a copy of the Client Rights and Responsibilities.

Client Signature:______________________________________Date: __________________

Staff Signature:_______________________________________Date: __________________