Demographic Information

First Name:_____Middle Name:_____Last Name: _____

Address:_____City:_____State:_____

Zip:_____County:_____SS#:_____-___-_____Date of Birth:_____ Age:_____

Phone #:_____May we leave a message ☐Yes ☐No Email:_____

Cell phone #:_____May we leave a message ☐Yes ☐No Receive Txt notifications ☐Yes ☐No

Race: _____ Sex:_____Marital Status: _____ # of Household members: _____

Employment Status:_____Work Number:_____May we call at work: ☐Yes ☐No Work hours:

Legal Guardian: _____Phone #:_____

Relationship to Client: _____

Emergency Contact:_____Phone #: _____

Referral Source: _____Phone #:_____

Name of the Pharmacy you use:_____Phone #: _____

Are you living in the US Lawfully: ☐Yes ☐No

School Attending:_____Grade: _____

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

Last Name:_____First Name:_____Middle Initial:_____Sex: ___

SS#:_____-____-_____ Date of Birth:_____Phone #: _____

Address:_____City:_____State & Zip: _____

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. However, we will allow no more than 60 days for payment. After 60 days, you will be billed for any outstanding balance on your account. All outstanding balances are due 10 days from the statement date. Late fees will be assessed at 10% of the balance. 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 STATEMENT OF UNDERSTANDING

Client Name: _____

This statement of understanding is intended to answer questions you may have regarding payment for services rendered by Insight Out Therapeutics and to serve as a financial agreement between the client listed above and Insight Out Therapeutics.

PAYMENT FOR SERVICES: Currently, we are credentialled with many different insurance companies. If your insurance carrier dictates a co-pay, co-insurance, or full payment at time services are rendered, you maintain full responsibility for paying all charges PRIOR TO BEING SEEN. In the event of an overpayment on your part, we will contact you directly and let you know that this occurred. You will have the option of payback or maintaining a credit on your account to be used for future sessions. In the event of an underpayment on your part, we will attempt ONE TIME to appeal to your insurance company. Any other attempts MUST be made between you and your insurance company, and you will be billed immediately for your balance. All outstanding balances are due 10 days from the statement date. Late fees will be assessed at 10% of the balance or $50.00 whichever is less. Failure to pay the balance 24 hours prior to next session will result in cancellation of your session and any other future sessions. Your therapist reserves the right to charge his session rate under the following circumstances: returning phone calls to clients and their attorneys, completing affidavits, writing letters on behalf of clients, etc. Account balances are due on date of service. Any balance greater than 45 days will result in administrative discharge from our services and your account will be submitted to a professional collection agency unless payment arrangements have been made.

SLIDING SCALE SERVICES: There are certain situations where a client may request and be offered a sliding scale cash rate lower than the posted rate for services. These situations will be considered only on a case by case basis and must be made in writing and submitted as hardships develop. We understand that circumstances sometimes warrant a change in the per session fee and will make every effort to work with you and your family to ensure that you continue to receive the same quality mental health services that are offered to anyone. Once the submission for sliding scale services has been received, it will be reviewed, and you will receive an answer within 72 business hours.

CANCELLATIONS: If you cancel your scheduled appointment less than 24 hours prior to the scheduled session, you will be charged a fee of $75.00, which must be paid before the beginning of your next session. Monday appointments need to be canceled no later than close of business on Saturday. To cancel an appointment scheduled on the day after a holiday, it needs to be canceled on the day prior to the holiday**. If 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. Failure to show for a total of 3 scheduled sessions without proper notification will lead to an administrative discharge from treatment.

STANDING APPOINTMENTS: Currently, we allow a client to have 3 future appointments on the schedule at one time. **If you miss an appointment without giving any notice at all, your future appointment times will be summarily cancelled, and you will no longer be afforded the convenience of having 3 sessions on the schedule and must make appointments one at a time.**

Signature or Client and/or Parent/Guardian:_____Date:_____

Administrative Signature_____Title:_____Date: _____

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.

PAYMENTS & CANCELLATIONS: Payment is due at the beginning of each session. We accept cash, personal checks and credit cards. Payment arrangements are discussed during your initial session. We also charge for our time when you require written correspondence that takes more than 20 minutes. This is billed according to the amount of time utilized with a minimum fee of $25. This would include correspondence such as letters to other practitioners, disability applications, etc. Because we offer tele-mental health, telephone consults are also billed at regular rates. **The first 14 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour.** Returned checks will incur a $35 returned check fee. It is necessary to give your clinician or the Insight Out Therapeutics administrative staff at least 24 hours advance notice if you need to cancel or reschedule an appointment. If you give less than 24 hours advance notice, you will be charged at the full session fee, which must be paid before the beginning of your next session. If you miss an appointment without giving any notice at all, you will be charged the full session fee, which must be paid prior to the beginning of your next session. Failure to show for 3 consecutive session without proper notification will lead to administrative discharge from treatment.

LEGAL SERVICES & COURT TESTIMONY: If your involvement in any legal matters leads to any Insight Out Therapeutics, LLC. clinician being subpoenaed or court ordered to appear in court on your behalf, you will be charged a minimum of$250.00 per hour for the time that the clinician spends preparing to testify, travel to and from court, waiting to appear, testifying, depositions, attorney correspondence/communication affidavits, etc. You are responsible for and agree to pay these charges whether or not the clinician ultimately testifies. An initial five-hour retainer is required to be paid prior to the court date.

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 reach our therapist on call by calling our main number (678-480-4477) or call the Georgia Crisis and Access Line for any mental health emergency 1-800-715-4225.

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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 I have any problem with my fellow participants or program staff is m y therapist. I 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.

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, 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 payment of 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: _____

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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;
23. Right to obtain a copy of the program's most recent completed report of licensing, accreditation, and inspection from the program upon written request within 30 days. The program is not required to release a report until the program has had the opportunity to file a written plan of correction for the violations as provided for in these rules; and (b) Such policies and procedures shall also include provisions for clients and others to present complaints, either orally or in writing, and to have their complaints addressed and resolved as appropriate in a timely manner.
24. Right to be informed of the program's complaint policy and procedures (investigation and resolution of alleged infringement of rights) and the right to submit complaints or appeal without fear of discrimination or retaliation and to have them investigated by the program within a reasonable period of time;
    a. Right to receive a written notice of the address and telephone number of that state licensing authority, which further explains the responsibilities of licensing the program and investigating client complaints which appear to violate licensing rules;

HealthCare Facility Regulation Division
Two Peachtree Street, NW
Atlanta, Georgia 30303-3142
Phone: 404.657.5700
Fax: 404.657.5708

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.

Advanced Directives Notice

An "Advance Directive" is a legal document in which an individual describes your personal health care choices should the time ever come that you are unable to speak for yourself, and there is little hope of recovery. The most common forms of Advance Directives are the Living Will and the Durable Power of Attorney for Health Care. These are rights under Federal and State Law:

1. You are not required to have an Advance Directive in order to receive treatment.
2. You have the right to accept or refuse treatment and to create an Advance Directive.
3. If you have an Advance Directive or decide to create one, Insight Out Therapeutics will honor it to the extent permitted by Georgia Law and in accordance with Insight Out Therapeutics' policies and procedures. Insight Out Therapeutics clinicians will not be able to follow your Advance Directive unless you provide a copy to the staff, verbalize your treatment preferences, or create a new document.
4. If your care provider cannot implement your Advance Directive on the basis of conscience she/he is obligated to transfer your care to a provider who will respect your wishes.
5. If you are a pregnant woman, your Advance Directive may not be honored once it is determined that the baby has developed enough to be able to survive if delivered, if applicable.
6. Executing a Durable Power of Attorney for Healthcare will assure that your designate agent will have access to your medical record.

To request an official Georgia Advance Directive Form or for further questions call 770-486-1140. For additional information on Advance Directives and to print forms you may go to www.caringinfo.org. Please bring a copy of your Advance Directive, if you have completed one, to be scanned into your medical record.

I 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 COPY

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 of Section 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

Patient's Rights:

• *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.

Therapist's Duties:

• 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 by a 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).

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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

Client Orientation for Services Acknowledgement

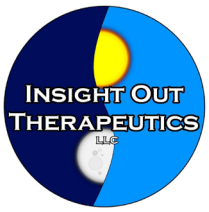
Name:_____ Date:_____

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: _____



Treatment Plan Signature Form

By signing below I am acknowledging that I have participated and received a copy of my treatment plan. I also agree with the plan as well as service recommendations to be provided by Insight Out Therapeutics, Inc. I am also committing myself to achievement of the goals listed within this services plan to the best of my ability in cooperation with my treatment team members.

Client Name Date

Client Signature

Parent / Legal Guardian Name (if applicable) Date

Parent / Legal Guardian Signature (if applicable)

Staff Name Date

Staff Signature & Credentials Date