Outpatient Services Admission Packet

Client Information:

Last Name | First | Middle/Maiden | Date of Birth | Age | M/F | Social Security #

Address | Cell Phone # | Home Phone #

City | State | Zip | Marital Status | Employment Status

Occupation | Employer | Address | Phone #

Email Address

Spouse / Significant Other Information:

Last Name | First | Middle/Maiden | Date of Birth | Age | M/F | Social Security #

Address | Cell Phone # | Home Phone #

City | State | Zip | Marital Status | Employment Status

Occupation | Employer | Address | Phone #

Guarantor Information:

Method of payment

Last Name | First | Middle/Maiden | Date of Birth | Age | M/F | Social Security #

Address | Phone # | Alt. Phone #

City | State | Zip | Marital Status | Employment Status

Occupation | Employer | Address | Phone #

#1 Emergency Contact:

Last Name | First | Middle/Maiden | Relationship

Address | Phone # | Alt. Phone #

City | State | Zip

Referral Information:

Referred by | Agency

Address | Phone # | Fax #

City | State | Zip

Insurance Information (Primary):

Insurance Carrier

Policy Holder | Relationship | Policy # | Group #

Address | Phone # | Alt. Phone #

City | State | Zip

Insurance Information (Secondary):

Insurance Carrier

Policy Holder | Relationship | Policy # | Group #

Address | Phone # | Alt. Phone #

City | State | Zip

CONSENT TO TREATMENT

I, _____, agree to participate in the Treatment Program at Santé Center Community Based Services. I understand the purpose of the therapy I am entering. I have been oriented by therapy staff. I have been informed of the following.

- **The condition(s) to be treated:**

  The conditions to be treated include any and all psychiatric diagnoses, including addictions.

- **The recommended course of treatment:**

  Santé Center for Community Based Services is an outpatient care facility. The length of our treatment program is a decision made by the client and their counselor. This decision is frequently influenced by the motivation for treatment (licensing boards for professionals, court requirements, severity of mental health disorders or severity of addictions).

- **The expected benefits of treatment:**

  Stabilization of mental health disorders
  "Tool box" of various tools.

- **Consequences of not consenting:**

  Inability to receive treatment from Santé
  Risk continuation of maladaptive behavior
  Risk further organic deterioration from mental health disorders and/or chemical addictions

- **Limits to confidentiality:**

  We make every attempt to protect your confidentiality. However, we are required by Texas state law to report physical or sexual abuse of a minor or of any adult who is not able to give informed consent if the abuse occurred in Texas. Licensed professionals are also required to report any violation of client sexual boundaries by physicians to the Texas State Board of Medical Examiners.

CONSENT TO TREATMENT (continued)

- **Risks associated with treatment:**

  Possible unintentional breach of confidentiality
  Possible side effects of medications, if prescribed
  Possible consequences if behaviors are required to be reported to authorities by federal or state law
  Possible increase in emotional distress when addressing "core issues", trauma and other stressful events
  Possible increase in negative consequences due to becoming rigorously honest with significant others

- **Generally accepted treatment alternatives based on appropriateness:**

  Outpatient treatment from a psychiatrist
  Appropriate Twelve-Step program
  Individual or group therapy

This consent is subject to revocation at any time by the client, except to the extent that the disclosure has already been made in reliance upon it. This consent will expire upon discharge from Santé treatment and aftercare.

Client:_____ Date:_____

Witness:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Client Name:_____

Signature:_____

Date:_____

Office Use Only

I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Client:_____ Date:_____

Witness: _____ Date:_____

RELEASE OF INFORMATION TO INSURANCE COMPANY

So as to permit reimbursement, I, _____ authorize Santé Center Community Based Services or any agent thereof that is or may be liable under a contract to Santé Center Community Based Services to disclose such treatment information pertaining to this treatment to:

_____
Insurance Company

_____
Address

_____ _____
City, State, Zip Code Phone #

For payment of all or part of the charges for services rendered or to be rendered to the patient. I understand that the purpose of any release of information is to facilitate reimbursement for services rendered and to be rendered.

In addition, in the event that my health program includes Utilization Review of services provided during this admission, I authorize Santé Center Community Based Services to release only such information as is necessary to permit the review.

I understand that this authorization to release treatment information is subject to revocation at any time except to the extent that action has been taken in reliance thereon. In any event, this authorization will expire once reimbursement for services rendered is complete.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any type whatsoever arising out of any and all insurance policies and health benefit plans insuring the patient or any dependents, said benefits are hereby irrevocably assigned to Santé Center Community Based Services for application to the patient's account. This assignment shall be for the purpose of granting Santé Center Community Based Services an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of Santé Center Community Based Services to pursue any such right of recovery.

Client: _____ Date: _____

Witness: _____ Date: _____

REMINDER: Your insurance company/employer benefits plan stated above are not contracted with us to pay for your medical care and at times authorize payment for services that are not covered in your plan. We will file your claims as a courtesy, but remember that you are ultimately responsible for payment of your account.

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

I, _____, Date of Birth _____, Social Security Number _____-___-_____
Request and authorize Sante' Center Community Based Services to:

_____Release information to _____ (please initial)
_____Obtain information from _____ (please initial)
_____Exchange information with _____ (please initial)

_____
Name of person or organization

_____
Street address

_____
City/State/Zip Code

_____
Phone # Fax #

The specific extent of information listed below pertaining to the following dates of treatment or consultations:

Dates of treatment or consultation: _____

_____Admission record	_____Physical exam	_____Alcohol/drug usage information
_____Consultation reports	_____Physician orders	_____HIV/AIDS information
_____Diagnosis	_____Progress notes	_____Family therapy
_____Discharge summary	_____Psychiatric evaluation	_____Phone consultation
_____Educational evaluations	_____Psychological tests	_____Other (specify)-Financial
_____History	_____Social history	_____

Reason for release of information:
_____Continued medical care _____Legal _____Other (specify) _____

Client/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

I understand that I may revoke this consent at any time by giving written notice to the Medical Records department of Santé Center Community Based Services except to the extent that action has been taken in reliance thereon. I further understand that the above consent will automatically expire one year from the date of signature.

Confidentiality Notice: The information contained in this document has been disclosed to you from records that are protected by **Federal Law 42 CFR Part 2** and you are prohibited from making any further disclosure without specific written consent of the person to whom it pertains. This information is intended for the person or entity to which it is addressed. If you are not the intended recipient or agent, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this document in error, please notify the sender immediately to arrange for return/destruction of these documents.

PATIENT GRIEVANCE PROCEDURE

All patients are encouraged to use the Santé Center Community Based Services progressive grievance procedure:

1. File a grievance with direct care of counseling staff.
2. If not satisfied, file a grievance with on of the Facility Directors.
3. If not satisfied, file a grievance with the Administrator.
4. If not satisfied, file a grievance with the Board of Directors.
5. If not satisfied, complain to the TCADA.

A patient may submit the complaint in writing and will be assisted with pens, paper, envelopes, postage and writing.

A patient may seek a remedy for any complaint to any member of the staff at any time.

A patient may make a written or telephone complaint against any staff member or the agency by calling:

TEXAS COMMISSION ON ALCOHOL AND DRUG ABUSE
9001 N. IH 35
SUITE 105
AUSTIN, TX 78753-5233

1-800-832-9623

A patient will be informed in writing within 10 days of the findings and recommendation of Santé Center Community Based Services.

Please initial:

_____ I have read and understand the patient grievance procedure.

_____ I have received a copy of the patient grievance procedure.

_____ _____ _____ _____

Client Date Witness Date

Community Based Services

We would like to take this opportunity to thank you for choosing Sante Center for Healing, Community Based Services for your continued recovery. Our goal is to provide quality services in a pleasant, friendly and efficient atmosphere. In order to meet this goal, we need your assistance and understanding of our financial policies. Our financial policy is a necessary part of assuring our ability to continue providing the best possible care to our clients.

Outpatient Financial Agreement

I , _____ , accept responsibility for payment of all fees and charges related to my treatment at Santé Center for Healing, Outpatient Services. Payment for services is expected in advance of treatment. The services offered & their related costs are listed below.

Sante Center For Healing – Community Based Services Fee Schedule

Individual Therapy, by Sante' Staff	$ 80.00 per hour	Couples Therapy, by Sante Staff	$ 150.00 per hour
Family Therapy (2 hour minimum)	$ 150.00 per hour	Injections	$ 20.00
EMDR	$100 per hour	No Show Fee	$ 50.00
Dietician/Nutritionist	$ 120.00 per hour	Equine Group Therapy	$ 80.00 per group
Drug Screening, Random	$ 39.00	Medical Prof Lab (764865 or 764875)	$ 86.00
SDI-R or PSI - CSAT Testing	$ 150.00 each	Psychological Testing	Varies – Avail upon request
Hair Follicle Test VI (6946)	$ 490.00	Hair Follicle Test III (6943)	$ 415.00
MSI II Testing	$ 55.00	Hair Follicle Test V (6945)	$1005.00
Returned Check Fee	$ 40.00	Boundaries Course	$1000.00

If you are unable to attend a scheduled appointment, we require that you call your therapist or case manager, no later than 9am the day of your appointment & provide an explanation for your absence. If the absence is unexcused or a call is not received by 9am, you will be charged a no show fee.

Any refunds or reimbursements due on the patients account will be refunded to the financially responsible party that has signed this agreement. Refunds will be made via check & no sooner than sixty (60) days after the patient has been discharged from treatment. In the event insurance payments are received following a patients discharge, insurance refunds will be issued no sooner than sixty (60) days after receipt of payment. Collection issues or other financial issues between Sante Center for Healing, Outpatient Services and the client and/or responsible party will be governed by the laws of the state of Texas.

As a courtesy to our clientele, Sante Center for Healing, Community Based Services will bill your insurance for your reimbursement; however, it is our policy to require payment in advance of services rendered. We will make every attempt to collect from your insurance company. But, we cannot guarantee reimbursement and you are ultimately responsible for all payments due on your account. Your insurance can only be billed if you attend your appointment, any unexcused absences or no show fees will be your responsibility.

I have received a copy of this financial agreement.

_____ _____

Patient Signature Date

_____ _____

Financially Responsible Party Signature Date

_____ _____

Witness Signature Date