

PATIENT INFORMATION:

Patient Name: _____ SS#: _____ Sex: M F

Address: _____ D.O.B. _____ Age: _____

City: _____ State: _____ ZIP: _____ County: _____

Home # _____ Cell # _____ Race _____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Student ___ Employed ___ Retired ___ Unemployed _____

Employer: _____ Occupation _____

Address: _____ Work # _____

City: _____ State: _____ ZIP: _____

EMERGENCY CONTACT:

Name _____ Relationship: _____

Home # _____ Cell #: _____ Work #: _____

RESPONSIBLE PARTY OR GUARDIAN:

Name: _____ SS# _____ Sex: M F

Address: _____ D.O.B. _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ W #: _____

Relationship to Patient: _____ Employer: _____

INSURANCE: (PLEASE GIVE CARD(S) TO FRONT DESK TO SCAN & CALL FOR BENEFITS)

1st Insurance: _____ Subscriber: _____

2nd Insurance: _____ Subscriber: _____

Referred by: _____ Primary Care Physician: _____

Name of other behavioral health provider: _____

I (do) wish _____ I do (NOT) wish _____ to have information shared with:

Medical physician _____ Other Behavioral health provider _____

I verify the information provided is true and accurate and authorize this facility to contact any insurance, employer, or guarantor listed to confirm or authorize treatment.

Patient, Responsible Party if a minor or Guardian

Date

A. CONSENT FOR TREATMENT

I understand that the treatment of the above-named patient or I will receive at the Arthur Center is based on current principals or psychological, sociological and medical treatment. I also understand that results of treatment cannot be warranted or guaranteed in any way. I hereby voluntarily apply and give consent for treatment of the above-named patient or myself. I further certify that I have been informed of my rights and responsibilities, or the rights and responsibilities of the above-named patient, as a client in a mental health facility.

B. AUTHORIZATION FOR CONSENT TO RELEASE INFORMATION

Authorization is hereby granted to Arthur Center and service related physicians to release to my insurance company or companies, their agents, Workerø Compensation carrier or employer and other third party payers, any information (including diagnostic and financial information) as may be requested or necessary for the completion of claim processing relative to my treatment. I also authorize disclosure of said information to any physician or Arthur Center to which I am referred.

C. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned, jointly and severally, hereby authorizes payment directly to Arthur Center and treating physicians for the insurance benefits otherwise payable to him/her or due to become payable to him/her for this medical treatment. I further agree that in the event hospital, surgical and medical insurance benefits exceed the amount due to Arthur Center for services in connection with my treatment, that any such excess amount may first be applied as payment of other indebtedness due to Arthur Center from me or my immediate family on account of other treatments and the balance, if any remains, refunded appropriately.

D. ASSIGNMENT OF MEDICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services rendered by Arthur Center, treating physicians to Arthur Center and treating physicians. I authorize Arthur Center and treating physicians to submit a claim to Medicare for payment.

E. RESPONSIBILITY OF BILL

In consideration of services rendered to the patient, I jointly or severally, do hereby agree to pay Arthur Center and treating physicians, and every account presented to me, or we jointly or severally, for said service(s) in accordance with the rates and terms of Arthur Center or the treating physician. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. Arthur Center cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, public body, or third part not signing this agreement. The undersigned accepts full financial responsibility for charges and for services not covered by insurance for which payment is denied through any utilization review or pre-admission certification procedures. Medicare patients will be responsible for payment of non-covered charges outlined in the Beneficiary handbook. All accounts are due and payable ninety (90) days from the date of discharge of the patient from the hospital.

Patient or Responsible Party / Date

Witness / Date



Your Rights

The following rights apply to all individuals receiving services without limits:

1. The right to reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, marital status, age or disability in the least restrictive environment;
2. To services delivered in a clean and safe setting;
3. To private and confidential services in accordance with state and federal laws;
4. To be treated with dignity and respect, in an age appropriate manner;
5. To care that is considerate and respectful of personal values and beliefs;
6. To participate in decision-making regarding treatment or have a legally-appointed representative or, if a minor, a parent participate on your behalf;
7. To be free of abuse, neglect, corporal punishment, humiliation, threats or exploitation;
8. To be informed of program rules;
9. To individualized care and treatment;
10. To be the subject of research only with one's informed, written consent, or the consent of an individual legally authorized to act on your behalf;
11. To medical care and treatment in accordance with accepted standards of medical practice when it is a part of the treatment process;
12. To be informed of expected benefits and risks including alternatives to treatment when available;
13. To be informed of the cost of your care and any personal responsibility for payment or have your legally-appointed representative informed of the same;
14. To request the opinion of a private consultant at your own expense, or request an in-house review of your treatment plan;
15. To a nourishing, well-balanced varied diet in residential settings;
16. To attend or not attend religious services in residential settings;
17. To communicate by sealed mail with Department of Mental Health, legal counsel, and court of jurisdiction;
18. To receive visits from one's family, attorney, physician, or clergy in private at reasonable times; and
19. To be paid for work unrelated to treatment, except that an individual may be expected to perform limited tasks and chores within the program that are designed to promote personal involvement and responsibility, skill building, or peer support. Any tasks and chores beyond routine care and cleaning of activity or bedroom areas within the program must be directly related to recovery and treatment plan goals developed with the individual.

The following rights are subject to limitation when they impact the individual's personal safety or the safety of others. Any limitation due to safety must be applied only on an individual basis, authorized by the President, documented in the individual's record, and justified by sufficient

Documentation and reviewed on at least a quarterly basis and rescinded at the earliest clinically appropriate moment. They include the following:

1. The right to review one's own record, except that specific information or records provided by other individuals or agencies may be excluded from such review. Upon request to review a medical record, the clinician involved with treatment will be informed and a staff person shall be present during the review;
2. In residential settings, individuals have the right to wear one's own clothes and keep and use one's personal possessions; keep and spend a reasonable amount of one's own funds; have reasonable access to make private telephone calls; to reasonably access current newspapers, magazine, radio and television programming; to be free of seclusion or restraint; to have opportunities for physical exercise and outdoor recreation; to receive visitors of one's choosing at reasonable hours; and to communicate by sealed mail with individuals outside the residential setting;
3. To ensure that all individuals have the same legal rights and responsibilities as any other citizen, unless otherwise limited by law;
4. To not be denied services based solely upon the grounds of prior treatment history, prior withdrawal from treatment against advice, or continuation or return of symptoms after prior treatment;
5. To provide policies, procedures, and practice to ensure prompt, responsive, impartial review of any grievance or alleged violation of rights including due process, assisting the individual to file a grievance, and to cooperate with a review or investigation by the Department of Mental Health or its authorized representative;
6. To promote the safety and well being of the individuals we serve by promoting therapeutic progress and assisting the individual in addressing barriers to recovery in including medication compliance, drug and alcohol use,

managing behavior and potentially lethal threats such as suicide and violence in a manner that respects the dignity of the individual as much as possible and according to state and federal law.

7. Clients may exercise their right to file a grievance or complain about services without fear of retaliation by any staff member of Arthur Center. If you suspect that a staff member is retaliating against you because you file a grievance, please call (573) 582-1234 and ask to speak with the President concerning a grievance.

Grievances/ Complaints

If an individual served believes one or more of the above rights have been violated, the following grievance procedure is in place to assure that the person has a prompt impartial review and resolution of the situation. If you need assistance filing a grievance, call (573) 582-1234 and ask for administration for assistance with this process. In addition, you may invite a family member, support person or advocate to assist you in this process. Our staff will gladly assist you in locating a person to assist you in advocating for your rights by calling (573) 582-1234 and ask for assistance. If you are receiving Department of Mental Health funded services from Arthur Center, you may call the Client Rights Monitor of MO Department of Mental Health at (800) 365-9687 or (573) 526-1201 TTY.

Grievance Procedure

1. Appeal directly to the staff member responsible for your treatment.
2. If the situation is not resolved to your satisfaction, you may ask to speak with the Program Director. The Program Director will respond in writing to any concerns within five (5) working days.
3. If the situation is still not resolved to your satisfaction, call (573) 582-1234 and ask for administration or you may send a written appeal to the President at 321 W. Promenade, Mexico, MO 65265. Within 5 days of the appeal, the President or designee will schedule a time to meet with you and review your concerns, or if you prefer, by telephone. The President will respond to your situation within 2 working days of the meeting.
4. If the situation is not resolved by the President review, the person may appeal directly, in writing, to the Arthur Center Board of Directors. The board may choose to meet with the individual or appoint a smaller group of board members to hear the situation. The Board will respond to your situation within five (5) working days of the meeting. This is the final level of appeal within Arthur Center.
5. If the situation is urgent and the safety of the client or others is in jeopardy, the individual may skip directly to step #3 for a fast-track resolution.
6. You may also initiate a complaint with your insurance company if we do not resolve the situation to your satisfaction.

I have been presented this Bill of Clients Rights and understand that I may request a copy at any time during the treatment process.

Signature of Client

Date

Witness

Date



**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT COVER SHEET**

Please have the consumer complete this cover sheet, and then tear off this cover sheet and file it in the consumer's medical record.

I, _____ (have client write name, or request staff assistance to do so), hereby acknowledge that I have received this Notice of Privacy Practices, with an effective date of April 14, 2003.

Consumer Signature or Legal Guardian Signature
or Parent of Minor Child Signature

Date

East Central Missouri Behavioral Health Services, Inc

d/b/a Arthur Center, Options Unlimited of Mexico, Options Unlimited of Fulton, Hope Center

Arthur Center

321 W. Promenade
Mexico, MO 65265
(573) 582-1234
(573) 582-1212 (fax)

Options Unlimited of Mexico

400 E. Liberty
Mexico, MO 65265
(573) 581-7887
(573) 581-1026 (fax)

Options Unlimited of Fulton

5060 County Road 306
Fulton, MO 65251
(573) 642-3215
(573) 642-7031 (fax)

Hope Center

709 Route O, P.O. Box 6010
Fulton, MO 65251
(573) 592-7500
(573) 592-7593 (fax)

CONSENT FOR THE RELEASE OF PROTECTED HEALTH INFORMATION for

Patient's full name (first, middle, last - please print)

Date of Birth

I hereby authorize the use or disclosure of my protected health information as specified below. I understand that this authorization is voluntary and that I may refuse to sign it and it does not prevent me from receiving services. I understand that this information is needed (1) to ensure continuity of care ____, (2) to monitor my response to treatment ____, (3) to assist in appropriate treatment planning ____, (4) other - specify _____.

____ I authorize the Arthur Center/Options Unlimited/Hope Center to release information to:

____ I authorize the Arthur Center/Options Unlimited/Hope Center to receive information from:

Name of Program/Person and Title

Address

City/State/Zip

Phone

Fax

The following information may be released or obtained:

____ Assessment

____ Treatment Plan and/or Reviews

____ Progress Notes

____ Discharge Summary

____ Psychological Testing

____ Lab Reports

____ Intakes/Evaluations

____ History & Physical

____ Insurance Information/Financial

____ Other-Please Specify: _____

For dates of service from _____ to _____.

I release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise sufficient safeguards while using this information. I hereby release Arthur Center/Options Unlimited/Hope Center and all employee from any and all liability, claims or causes of action for providing you medical information requested regarding treatment, hospitalization, outpatient care including psychological, psychiatric, drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency (AIDS), or test for infectin with human immunodeficiency virus (HIV).

Redisclosure:

I understand that information used or disclosed as a result of this release may no longer be protected by federal law, and could be re-disclosed by the receiving party. I have the right to inspect or request a copy of information that has been disclosed. If Arthur Center/Options Unlimited/Hope Center initiated the release of informatin, I have the right to a copy of the release. If additional questions, I understand that I can contact the Privacy Officer at any time by calling (573) 582-1234. A photocopy or faxed copy of this authorization shall be fully effective as valid for all purposes as the original hereof.

Expiration:

I understand that unless I revoke the authorization earlier, this authorization will automatically expire one (1) year from the date this Authorization was signed.

Client's Signature

Date

Parent/Legal Guardian Signature

Witness

Alcohol and drug abuse treatment information is specifically protected by federal regulations (42 CFR Part 2) that prohibits any further disclosure without the specific written consent of the person to whom it pertains, or as other wise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

NOTICE OF REVOCATION:

I hereby revoke the above authorization of this disclosure of protected health information to the agency/person listed previously. This revocation makes this previous authorization null and void. I do understand that any information previously disclosed cannot be retracted, however no additional information will be released without my written authorization.

Signature

Date Signed

Signature of Witness

Date Signed