PRE-INTAKE

DATE _____ *Do you need an Interpreter?* ___ Yes ___ No

FULL LEGAL NAME_____

DATE OF BIRTH ____/____/_____ **SOCIAL SECURITY #**_____-_____-_____

ADDRESS_____

CITY_____**STATE**____**COUNTY**_____**ZIP**_____

EMAIL_____

Check Preferred Communication

___Home Phone_____ ___Cell Phone/Text _____

___Do Not Contact ___ Regular Mail ___ Email

Marital Status: ____Legally Married ___Divorced___ Single/Never Married ___Separated ____Common Law

Primary Language: ___ English ___ Spanish ___Other _____

Race: ___ African Amerian ___ Caucasian ___American Indian ___ Other _____

Ethnic Origin: ___Hispanic ___ Not Hispanic ___ Mexican ___ Cuban ___Puerto Rican

Place of Birth (City, State and County)_____

Highest grade completed?_____

Employment Status: ___ FT ___PT ___ Disabled ___ Unemployed ___ Student ___ Retired ___Homemaker

Veteran___Yes___No

What type of insurance do you have? _____

Subscribers Name: _____ **Subscribers DOB:** _____

INDIVIDUAL INCOME $_____ **TOTAL HOUSEHOLD INCOME $**_____

Primary Source of Income: ___ Salary ___Public Assist. ___ Retirement ___Disability ___ None ___ Other

Are you pregnant? ___Yes___No **Hearing Status:** ___Hearing____Hard of Hearing____Deaf

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RESIDENTIAL CODE: ___ **Independent Living** ___**Private Residence (Children Only)** ___ **Other Institutional Set**
___ **Inpatient Psychiatric Hospital** ___**State Psychiatric Hospital** ___**Nursing Home** ___ **Jail/Correctional Facility**

Residential Arrangement: ____ Alone **OR WITH**: ___ Children ___Relatives ___Guardian ___ Non Relatives
____ With Paid Careprovider _____ Unknown

Next of Kin Name/Phone: _____

Emergency Contact Name/Phone: _____

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ALTAPOINTE HEALTH
STATEMENT OF UNDERSTANDING AND CONSENTS

CONSUMER NAME: _____

Review and initial each applicable area:

All Programs

_____ **Treatment/ Psychiatric Care**: I hereby authorize AltaPointe to provide me with treatment services, and if it is my child or ward, I hereby give consent for treatment:
Services may include the prescription of psychoactive medications and the administration of those medications by approved program staff. Emergency medications may be given to the consumer (by mouth or injection) to prevent harm to themselves or others.
Children and adolescent inpatient consumers will receive educational services on site as appropriate. Classrooms may consist of students receiving special and/or regular educational services. Due to our emphasis on treatment of emotional and behavioral difficulties consumers will not be eligible to receive the same number of credits as they would on a public school campus.

_____ **Consent for Follow-up contact:** I consent to AltaPointe staff members contacting **__myself ___other contact** by letter, questionnaire or telephone for establishing my current condition. I understand this information will be held in confidence and will not be disclosed without my written consent. I further understand this consent for follow-up will remain valid for a period of **ONE** year following my discharge from the program. I understand that I may revoke this consent at any time in writing. □ **I do not want to be contacted**.
Name: _____Address: _____ Phone#: _____

_____ **Health Information Exchange (HIE):** AltaPointe participates in a HIE called Care Quality. I understand that any physician or hospital that participates in the Care Quality HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You many chose to Opt-Out of allowing your health information to be shared through the Care Quality HIE by requesting an Opt-out form.
All other releases will follow the practices explained in Your Notice of Privacy Practices.

_____ **Payment Agreement:** For and in consideration of services rendered by AltaPointe, consumer (responsible person) herby agrees to and guarantees payment of all AltaPointe charges incurred for the account of the consumer from the date of admission until discharge. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive at AltaPointe. If the Probate Court placed me at AltaPointe, I understand that my insurance along with contract fees will be used to pay for services rendered while I am receiving services at AltaPointe.

I also understand that that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand I should contact AltaPointe if there are any changes to my insurance. A no-show fee may be charged if applicable.

Methods of Payment – Our office accepts the following payment methods: Cash, Personal Check, Credit Cards and Money Orders.
There will be a $25.00 NSF charge for all returned checks.

_____ **Fee Schedule:** I understand that I am responsible for payment for services rendered by AltaPointe Health, Inc. at its standard rates provided to me on the fee schedule.

_____ **Self-Pay –** I agree to pay AltaPointe in full for services rendered.

_____ **Medicaid:** Consumer certified that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Consumer authorizes any holder of medical or other information about Consumer to release to the respective State Medicaid Agency or its intermediaries or carries any information needed for this or a related Medical claim. Consumer requests that payment of authorized benefits be made on his/her behalf.

_____ **Medicare:** Consumer certified that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Consumer authorizes any holder of medical or other information about Consumer to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medical claim. Consumer requests that payment of authorized benefits be made on his/her behalf.

_____ **Assignment of Insurance Benefits and Agreement to Pay Any Balance**: Consumer (responsible party) irrevocably assigns and transfers to AltaPointe all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering consumer, for the payment of treatment and medical care being provided. Consumer (responsible party) authorizes payment directly to AltaPointe Health of said medical reimbursement benefits. Consumer (responsible party) is responsible for and co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the AltaPointe charge in full, consumer (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that AltaPointe does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.


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MR#: [ ][ ][ ][ ][ ][ ] EP: [ ][ ] Date: [ ][ ] – [ ][ ] – [ ][ ][ ][ ]
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AltaPointe Health Statement of Understanding and Consents pg. 2

_____ **Integrated Healthcare Pharmacy Services**: As a consumer at AltaPointe Health my prescriptions may, but are not required, to be filled at the Integrated Healthcare Pharmacy located at Gordon Smith Drive. AltaPointe Health has an ownership interest in Integrated Healthcare Pharmacy and offers the on-site pharmacy services for the convenience of the consumer. It is the consumer's decision as to where he/she chooses to fill their prescription.

_____ **Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment**: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

_____ **Family Involvement**: Family involvement is an integral part of treatment especially when treating children and adolescents. I agree to make every reasonable effort to assist my or my child's therapist in scheduling a convenient time for this family therapy session. I do understand that failure to meet this requirement can result in denials of insurance payment related to non-compliance with treatment.

_____ **Responsibility for Destruction of Property**: The undersigned understands that consumers are responsible for any damage to or destruction of AltaPointe property, or property belonging to others which may be located at AltaPointe. The undersigned and/or legal guardian agree to accept liability of, and reimburse AltaPointe or other owners of property which the consumer may damage or destroy.

_____ **Confidentiality of Information and Group Participation**: I understand that any information which is disclosed to me while I am a consumer at this facility is confidential and that this information is protected by Federal law. I understand that this means that I will respect the rights of other participants by not talking with others outside the facility about what is said in treatment groups.

_____ **Consumer Rights Statement**: I understand that AltaPointe subscribes to a Consumer Rights Statement, which has been made available to me. I have had the opportunity to have the Consumer Rights Statement explained to me.

_____ **Grievance Process**: I have been furnished with a copy of the Grievance process and had it explained to me.

_____ **Procedure to Review Records**: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

_____ **Notice of Privacy Practices**: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of _____ will be held in confidence by the AltaPointe staff unless I give specific written consent for the release of information. In case of emergency AltaPointe is authorized to request or release that information which is essential to handle the emergency.

Also, AltaPointe staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage or sabotage.

The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a consumer's commission of a crime against AltaPointe property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).

_____ **Special Equipment**: I understand that special equipment, in the form of cameras, may be utilized at the facility for the safety of the consumers.

_____ **Rehabilitation Act:** It is the policy of AltaPointe, in compliance with Section 504 of the Rehabilitation Act of I973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a compliant with the Consumer Needs Specialist, AltaPointe Health, 5750-A Southland Drive., Mobile, Al. 36693.

_____ **Consent to Photographs**: I consent to have my photograph taken by the staff at AltaPointe as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of consumer identification, and will be used for identification purposes only when necessary during the course of my treatment.

_____ **Consent to Search**: I do hereby give my willing and informed consent to AltaPointe to search my personal belongings in my presence. **This consent is given to ensure that neither I nor anyone else in this facility has any prohibited items (dangerous objects, medications, contraband, or any other prohibited items)**. I do understand that this search would also be performed in the event of my leaving the facility by the appropriate clinical staff member as AltaPointe deems necessary. I do also understand that this search is to include socks and underwear.

_____ **Responsibility for Personal Articles**: Consumer (responsible person) acknowledges and agrees that AltaPointe does not assume responsibility for any personal possessions. Consumer and/or legal guardian acknowledges and agrees to accept responsibility for any personal possessions. Consumer acknowledges and agrees to accept responsibility for clothing and/or personal effects including dentures, eye glasses, hearing devices, etc.

_____ **Psychiatric Advance Directives:** ***(All Adult Programs)*** ___ I have a psychiatric advance directive and have provided a copy to AltaPointe. ___ I do not have a psychiatric advance directive, and have been provided information by AltaPointe

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Children's Outpatient Programs

_____ **Children's Outpatient Program Admission Agreement**: I have been furnished with a copy of the admission agreement and it has been explained to me.

Residential / Hospital Program

_____ **Seclusion & Restraint: The Last Resort**: I understand that AltaPointe's policy is to use Seclusion and Restraint only as a last resort. I have been given a copy of their policy and had the opportunity to ask questions. Physical restraint and/or seclusion may be used only in an emergency to protect the consumer or others from imminent risk of harming self or others. This procedure has been explained to me. I understand that this is not used as punishment, but only as an emergency procedure. I understand that an attempt will be made to contact:
Name _____ Relationship: _____
Phone Number: _____.

_____ **Consent for Participating in and Transport to Off-Ground Activities and therapies**: I give permission for me or my child to participate in off-ground activities such as movie, skating, museums, bowling, plays, etc., as approved by the attending physician. I understand that AltaPointe will provide reasonable supervision and will take reasonable precautions to provide for the safety and well-being of me and/or my child.

_____ **Adult Residential Services and Transitional Age Residential Financial/Medical/Dental Responsibility Agreement:** As a resident of a residential care home, I understand that (1) I am charged up to 75% of my monthly income or up to $750 for room and board. (2) My room, board charges may be changed if my income changes. I am responsible for up to 75% of all my income for room and board for those months for which I am eligible. (3) I will reimburse the program for all personal expenses incurred while a resident at AltaPointe Health to include, but is not limited to, any property damage personally created. (4) I understand that AltaPointe provides no routine medical and dental care. The provision of payment for routine and major medical costs must be made prior to admission through consumer resources, acceptable third party, or warranty by the sponsoring agent. I understand that I will be responsible for all my medical and dental care. If my relative/guardian/sponsor accepts responsibility for my medical and dental care, the signature is affixed below.

_____ **Child/Adolescent 24 Hour Care Program Elopement Report Permission**: I hereby give my permission as parent/legal guardian for the staff at AltaPointe to notify local law enforcement (police and/or sheriff's departments) of my child's full identity in the event of his/her unauthorized elopement from AltaPointe and/or the grounds. Identifying information may include name, birth-date, name(s) of parent(s), home address, and any other identifying information deemed potentially helpful in such a report.

_____ **Emergency Medical/Surgical Services**: I authorize and give my consent to AltaPointe staff to seek and obtain emergency medical/surgical treatment or dental treatment services as needed.

_____ **Medical Advance Directives:** ___I have a medical advance directive and have provided a copy to AltaPointe. ___I do not have a medical advanced directive, and have been provided information by AltaPointe.

_____ **Consent for Sex education**: State and National Guidelines for child/adolescent treatment facilities require that the consumers be offered the chance to participate in sex education classes. AltaPointe will offer these classes on an informational level to those consumers who are of age to make their own informed decision or whose parents/guardians wish to have them enrolled. I give consent for my child to participate in informational sex education classes.

_____ **Consent to Attend Church-Related Activities**: I agree or give permission for my child to attend church-related activities while a consumer at AltaPointe. **(24 hour care programs)**

_____
Print Consumer's Name Consumer's Signature Date

_____ _____
Parent/Legal Guardian Signature Date Witness Signature/Credentials Date

_____
Witness Signature/Credentials **(required when signed with a mark)**

If consumer signature is not present mark reason:

_____ Consumer Unable to Sign

_____ Consumer refused to Sign (Show multiple attempts)
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____

Your rights as a Consumer at AltaPointe Health

At AltaPointe Health, our goal is to make sure you get the quality mental health care you need. In order for you to get good care, there should be trust and respect between the consumer and those who give that care.

No consumer shall be refused services based upon their inability to pay.

When you are a consumer at AltaPointe Health you have the right to:

- Be treated with respect, dignity and privacy.
- Be treated in a safe and humane place.
- Know the facts about your care, which has been designed just for you.
- Know the facts about your medicine.
- Be told where to get help if you have pain or other medical problems.
- Get help from others.
- Give your written consent for treatment.

Facts about your care .... You have the right to:

- Be told what your illness is and what the doctor thinks is the best way to treat it,
- Be told how long your treatment will last,
- Be told the cost of your treatment and what part your insurance will pay, and if there are any limits on your treatment,
- Be told the rules about behavior in the program.

Facts about your medicine ... You have the right to:

- Take medicine only if ordered by a doctor,
- Be told about your medicine, including information about any side effects you may expect and how the medicine will help you,
- Refuse to take any medicine, unless your care and treatment has been ordered by the court.

Making decisions about your care ... You have the right to:

- Have a treatment plan set up for your needs and to have it reviewed on a regular basis.
- Help plan your treatment and have your family participate if you want.
- Get your treatment in the place that is the least restrictive for you.
- Refuse any treatment unless it has been ordered by a court.

Getting help from others ... You have the right to:

- Get a second opinion, at your expense.
- File a complaint and get an answer to your complaint about services or treatment.
- Talk to an attorney.

- Have contact with the court system.
- Talk to a pastor or minister and to worship in the faith of your choice.
- Access protective services.
- Pray if you want to.
- Get proper, healthy meals.
- Have your personal belongings and clothing to wear.
- Have visitors, to send or get mail and phone calls in private.
- Not be put into isolation or restrained or put on drugs unless as a part of your treatment.
- Refuse to do any work that would financially benefit AltaPointe Health.
- Get a free public education if you are of school age.
- See a doctor or dentist and get the health care you need (at your own expense).
- Formulate or have your Advanced Directive honored.

You have duties too. You should:

- Respect other people
- Talk to our staff
- Not touch other people in the wrong way
- Not run away
- Not break things
- Take your medicine
- Follow the rules
- Join in activities
- Do your chores
- Not hurt other people or fight

If you feel that any of your rights have been violated or if you want further information, you may contact the following:

Department of Mental Health – Mental Retardation Office of Advocacy Services
1-800-367-0955

Department of Human Resources
(251) – 450-1800

Alabama Disabilities Advocacy Program
1-800-826-1675

AltaPointe Health Consumer Needs Department
(251) 450-4303

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe Health by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org

You may also call:

Elder Care at Public Health in Montgomery/Division of Health Care Facilities to report a complaint and/or ask questions about your Advance Directive at 1-800-356-9596, Monday – Friday 8 AM to 5 PM.

Revised: 4/23/2018
NB-41

GRIEVANCE PROCESS

You may report any complaint/grievance to any employee of AltaPointe Health. All complaints received will be reported to the Consumer Needs Specialist.

- You will receive a response with possible solutions to you complaint within 10 working days from the Consumer Needs Specialist.
- If you are not satisfied with the solution, you may request that your complaint be reviewed by the Consumer Needs Committee.
- You will receive a response with a possible solution from the Consumer Needs Committee within 10 working days.
- If you are not satisfied with the solution offered by the Consumer Needs Committee, you may request that your complaint be reviewed by the Chief Executive Officer of AltaPointe Health.
- You will receive a response from the Chief Executive Officer within 30 days.

At any time, you may contact the following agencies regarding your complaint/grievance.

Department of Mental Health/Mental Retardation Office of Advocacy Services
(800) 367-0955

Department of Human Resources
(251) 450-1800

Alabama Disabilities Advocacy Program
(800) 826-1675

Consumer Needs Department
(251) 450-4303

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe Health by either calling (800) 994-6610 or emailing complaint@jointcommission.org

You may also call:

Elder Care at Public Health in Montgomery/Division of Health Care Facilities to report a complaint and/or ask questions about your Advance Directive.
(800) 356-9596
Monday-Friday 8am-5pm

AltaPointe Health

Procedure for Review of Records

Any consumer or legal representative of a consumer may request an opportunity to review his/her records to obtain information from his/her records at AltaPointe Health. Such a request must be submitted in writing on a facility provided *Release of Authorization to Disclose Protected Health Information* form.

Upon receipt of this request, the Health Information Department shall forward the consumer's request and medical record to the clinician for determination if release of information would be detrimental to the consumer.

If after review the clinician determines the information may be released, the requested information will be copied and released to the consumer.

The copying fee for such requested records is:

On disc: $6.50 disk fee
On paper: $5.00 labor fee, $1.00 per page for the first 25 pages, $0.50 per page thereafter
$15.00 Certification fee if requested

Requests for Release of Health Information not completed and witnessed at one of our facilities require a notarized validation of identity of the requestor.

Appeal Process

Step 1: You may report any complaint/grievance to any employee of AltaPointe. All complaints received will be reported to the Consumer Needs Specialist. You will receive a response with possible solutions to your complaint within 10 working days from the Consumer Needs Specialist.

Step 2: If you are not satisfied with the solution you may request that your complaint be reviewed by the Consumer Needs Committee. You will receive a response with a possible solution from the Consumer Needs Committee within 10 working days.

Step 3: If you are not satisfied with the solution offered by the Consumer Needs Committee you may request that your complaint be reviewed by the CEO of AltaPointe Health. You will receive a response from the CEO within 30 days.

At any time you may contact the following agencies regarding your complaint/grievance:

Department of Mental Health – Mental Retardation Office of Advocacy Services
1-800-367-0955

Alabama Disabilities Advocacy Program
1-800-826-1675

Consumer Needs Specialist
(251) 450-4303

Department of Human Resources
(251) 450-9100 (Children) or (251) 450-1800 (Adult)

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about ALTAPOINTE by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

AltaPointe Health
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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

We have a legal duty to safeguard your (PHI) Protected Health Information. This PHI includes information that can be used to identify you that we have created or reviewed about your past, present or future health conditions. It contains what healthcare we have provided to you, or the payment history on healthcare related accounts. We must provide you with notice about our privacy practices and explain how, when and why we use and disclose your PHI.

We will not use or disclose your health information without your authorization, except as described in this notice or otherwise required by law. We are legally required to follow the privacy practices that are described in this notice.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS:

The confidentiality of alcohol and drug abuse records maintained by this organization is protected by federal law and regulations. Generally, the program may not communicate to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser unless one of the following conditions is met:

* you consent to it in writing
* the disclosure is allowed by a court order
* the disclosure is made to medical personnel in a medical emergency or to qualified personnel for program

Violations of federal laws and regulations by a program are a crime. Suspected violations may be reported to the appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by you either at the program or against any person(s) who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

YOUR HEALTH INFORMATION RIGHTS:

Although your medical record is the physical property of AltaPointe Health, the information belongs to you. You have the right to:

* request in writing a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
* request in writing to obtain a paper copy of your health record as provided for in 45 CFR 164.524
* request in writing to amend your health record as provided in 45 CFR 164.526
* obtain a paper copy of the notice of information practices upon request
* request in writing to obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request in writing communication of your health information by alternative (other) means or at other locations
* revoke in writing your authorization to use and disclose health information except to the extent that action has already been taken
* obtain notice following any breach of your unsecured protected health information as provided in 45 CFR 164.520(b)(1)(v)(A)

OUR RESPONSIBILITIES:

AltaPointe Health is required to:

* maintain the privacy of your health information
* provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate health information by other means or at other locations
* train our personnel concerning privacy and confidentiality; implement a sanction policy to discipline those who breach privacy or confidentiality of our policy

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our Information practices change; the revised notice will be available through your therapist and in the lobby of the facility.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the Consumer Needs Specialist at 251-450-4303.
If you believe your privacy rights have been violated you can file a complaint with the Consumer Needs Specialist at AltaPointe Health or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Your written statement to AltaPointe Health and/or the Office of Civil Rights must include your name; address; telephone number; your signature; how, why, and when you believe you were discriminated against; name and address of institution or agency you believe discriminated against you; and any other relevant information.

You may submit in writing a request for review of any discrepancy or complaint under HIPAA to any of the following:

Director
Office of Civil Rights
U.S. Department of Health & Human Service
61 Forsyth St., SW – Suite 31370
Atlanta, GA 30323
(404) 562-7858 or 562-7884

Consumer Needs Department
AltaPointe Health
5750-B Southland Drive
Mobile, AL 36693
(251) 450-4303

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment (for example):
Information obtained by a, doctor, nurse or other mental health professional will be recorded in your record and used to determine the course of treatment that will work best for you. Any service provided to you will be documented in the record.

We will use your health information for payment (for example):
A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. You may request restrictions on such uses only if the request relates to services paid of out-of-pocket and the request is for nondisclosure to a health plan related solely to such services as provided in 45 CFR164.520(v)(1)(iv)(a) and 164.522(a)(1)(vi)

We will use your health information for regular health operations (for example):
Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Business Associates:
We provide some services through contracts with business associates. (Example: certain diagnostic tests).

Directory:
We do not have a directory that provides any information concerning your treatment here.

Notification:
We will not disclose any information to anyone about you without your written consent/authorization. Examples of uses or disclosures requiring your authorization include most disclosures of psychotherapy notes as provided in 45 CFR 164.520(b)(1)(ii)(E)

Comm*unication with Family:*
Only with your written authorization/consent will we disclose to a family member, another relative, a close friend, or any other person that you identify; health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Funeral Directors:
We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing/continuity of care:
We may contact you to provide appointment reminders or information about treatment alternatives that may be of interest to you.

Fund raising:
We will not contact you concerning any fund raising activities.

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarking surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:
We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
We may disclose your health information as required by law.

Correctional institution:
If you are an inmate of a correctional institution, we may disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement:
We may disclose your health information for law enforcement purposes as required by law or in response to a court order.

Health Oversight Agencies & Public Health Authorities:
By Federal law provisions your health information may be released provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more consumers, workers or the public.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (MEDICAL RECORDS) THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL HAVE THE REVISED NOTICE AVAILABLE IN THE THERAPIST'S OFFICE AS WELL AS HAVE A SUPPLY AVAILABLE IN THE LOBBY OF THE FACILITY.

EFFECTIVE DATE: **04/14/03**
Revised 4/23/2018
NB- 30

PSYCHIATRIC ADVANCE DIRECTIVES
INFORMATION FOR CONSUMERS

What is a psychiatric advance directive? A psychiatric advance directive (PAD) is a written document that describes your directions and preferences for treatment and care during times when you are having difficulty communicating and making decisions. It can inform others about what treatment you want or don't want, and it can identify a person called and "agent" who you trust to make decisions and act on your behalf.

Should I have an agent? You have the option of naming an agent:

- Who is at least 19 years old
- Who knows you and knows what you want when you are doing well

Can I write a legally-binding psychiatric advance directive? Yes. The Alabama Durable Power of Attorney Act allows you to appoint an "agent" to make healthcare decisions about mental health. The statutes include a form called "Advance Directive for Health Care". It is not mandatory for you to use that form, but it is advisable to do so.

You would include "other directions" on your form, which could include directions about mental health treatment. If you wish to write advance instructions about psychiatric medications and/or hospitalization, it is advisable to set out your wishes clearly in the "Mental Health Advance Directive" form. This form will still be valid even if you leave the end of life section blank.

Will everything in my psychiatric advance directive be followed? Your mental healthcare providers could decline to follow your instructions or those of your agent if the instructions concerned one of the excluded types of treatment, or if you were hospitalized or medicated under Alabama involuntary treatment laws.

Who should get a copy of my psychiatric advance directive? I you have named an agent, that person must be given a copy. After that, it is up to you who you give a copy to. You should think about giving one to your current mental health provider. Any treatment provider who gets a copy is required to make it part of your medical record.

How long does my psychiatric advance directive remain valid? The document appointing your agent is valid until you revoke it. It may be revoked in writing by you or someone else directed by you. If you destroy or deface it, it will also be assumed to be revoked. If you appoint your spouse as you agent and you divorce or legally separate after you wrote the document, your spouse would no longer be a valid agent. Be sure to notify everyone who has a copy if you revoke it or make any changes.

10/21/2011

PSYCHIATRIC ADVANCE DIRECTIVE

Consumer Name_____ **MR #** _____

If you are hospitalized for mental health care in the future and aren't able to make decisions about your treatment, an advance directive will make your treatment preferences known. It is important that you decide **NOW** what types of treatment you want, and appoint a friend or family member to carry out your mental health care choices.

Read each section of the form carefully and discuss your choices with your treatment staff or other trusted person.

You can change your advance directive at anytime you are competent to do so. Your advance directive will not take effect unless a physician decides that you are incompetent to make your own treatment decisions. It is a good practice to carry a copy of the advance directive with you when you travel.

****

I, _____, being of sound mind, willing and voluntarily, execute this psychiatric advance directive to insure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decision for myself.

If a guardian or other decision-maker is appointed by a court to make health care or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes and it should be given the greatest possible legal weight and respect. If the agent(s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions.

If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental health care agent to make certain treatment decisions for me. My agent is also authorized to apply for public benefits to defray the cost of my mental health care, to release information to appropriate persons, and to authorize my transfer from a health care facility.

This power of attorney shall become effective upon the disability, incompetency or incapacity of the Principal.

My mental health care agent is:

Name: _____

Address: _____

Telephone #: _____

Comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

PSYCHIATRIC ADVANCE DIRECTIVE page2

Consumer Name_____ **MR #** _____

I, _____, mental health care agent

designated by _____, hereby accept the designation.

_____

Signature of Mental Health care agent Date

_____

Complete the following and initial in the blank marked yes or no:

A. If I become incompetent to give consent to mental health treatment, I give my mental health agent full power and authority to make mental health care decisions for me. This includes, the right to consent, refuse consent, or withdraw consent to any mental health are, treatment, service, or procedure, consistent with any instructions and/or limitations I have state in this advanced directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision my agent determines is the decision I would make if I were competent to do so:
_____ YES _____ No

B. My choice of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24-hour care, I would prefer to receive this care in this/these facilities:
   Facility: _____
   Facility: _____

2. I do not wish to be placed in the following facilities for psychiatric care:
   Facility: _____
   Facility: _____

C. My choice of a treating physician is:

First choice of physician: _____
Second choice of physician: _____

I do not wish to be treated by the following physicians:

Name of Physician: _____

D. My wishes regarding confidentiality of my admission to a facility and my treatment while there are as follows:

1._____ My representative may be notified of my involuntary admission. ____ yes ____ no
2._____ Any person who seeks to contact me while I am in a facility may be told I am there. ____ yes ____ no
3_____ I consent to release of information about my condition and my treatment plan. ____ yes ____ no
To the following person: _____

4_____ I do not consent to the release of information about my admission or treatment to anyone unless I give specific consent at the time of the request or as otherwise allowed by law. ____ yes ____ no

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health, I have initials one of the following, which represents my wishes:

1._____ I consent to the medications that Dr. _____ recommends.
2._____ I consent to the medications agreed to by my mental health care surrogate, after consulting with my treating physician and any other individuals my surrogate may think appropriate, with the exceptions found in # 3 below.
3._____ I specifically do not consent and I do not authorize my mental health care surrogate to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents: (list name of drug and reason for refusal).
_____
_____
4._____I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.
5. _____I have the follow other preferences about psychiatric medications: _____

PSYCHIATRIC ADVANCE DIRECTIVE page3

Consumer Name_____ **MR #** _____

F. My wishes regarding Electroconvulsive Therapy (ECT) are as follows:

1. _____ My agent may not consent to ECT without express court approval.
2. _____ I authorize my agent to consent to ECT.
3. _____ Other instructions and wishes regarding ECT are as follows: _____

_____

G. If, during a stay in a psychiatric facility my behavior requires an emergency intervention, my wishes regarding which form of emergency interventions should be made in the following order as indicated by the number.. If an intervention you prefer is not listed, write it in after "other" and give it a number.

___ Seclusion
___ Physical restraints
___ Both seclusion & restraints
___ Other: _____

___ Medication in pill form
___ Medication in liquid form
___ Medication by injection

H. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility.

Name: _____ Relationship: _____
Address: _____
Telephone #: _____

Name: _____ Relationship: _____
Address: _____
Telephone #: _____

By signing here I indicate that I fully understand that this advance directive will permit my mental health agent to make decisions and to provide, withhold, or withdraw consent for my mental health treatment.

Printed Name: (Consumer): _____

Signature: _____ Date: _____/_____/_____

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the agent. I am not related to the person by blood, adoption, or marriage. I am at least 19 years of age and am not directly responsible for paying for his or her care.

Name of first witness: _____

Signature: _____Date: _____/_____/_____

Name of second witness: _____

Signature: _____Date: _____/_____/_____

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION

I, _____ hereby consent to the verbal/ email exchange of information between
(Print consumer name)

AltaPointe Health and: _____
(Name of person or organization or email address information will be discussed with)

regarding_____
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (Two year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Consumer Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

Revised: 2/7/18
BC 01004

01004

MR#: | | | | | | | EP: | | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR PSYCHIATRIC TELEHEALTH SERVICES

Patient Name: _____

Healthcare Practitioner: AltaPointe Health Credentialed Provider

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual consumer health information for the purpose of improving consumer care. **This consent is valid for twelve months.** The information obtained may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following:

- Live two-way audio and video
- Output data from medical devices and sound and video files

The interactive tele-video equipment and telecommunication lines used are HIPAA approved for consumer security and privacy.

Expected Benefits

- Improved access to psychiatric care by enabling a consumer to have a session with a psychiatrist while remaining at a remote site,
- More efficient medical evaluation and management.

Possible Risks

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment,
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of psychiatric information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to other entities without my written or verbal consent.
2. I have the right to withhold or withdraw my consent (either written or verbally) to the use of telehealth in the course of my care at any time.
3. I understand that the health care provider is off site at a remote location.
4. I understand that none of the teleconference will be recorded or photographed.
5. I understand that in the event of technical difficulties an employee of the IT department, as well as additional staff, may be present during my session.
6. I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
7. If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:_____
8. The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
9. I will be informed of all people who will be present at all sites during my telemedicine service.
10. I may exclude anyone from any site during my telehealth service.
11. I may see an appropriately trained staff person, or employee, in-person, immediately after the telemedicine service if an urgent need arises. **OR,** I will be told ahead of time that this is not available.
12. I may contact the healthcare provider at phone number _____ for any questions I have related to medical services received through a telemedicine provider/site.

I understand that this consent will expire on _____ (Twelve months from the signature date) **or** at the time of my discharge from this program, whichever comes first.

I have read this document carefully, and my questions have been answered to my satisfaction.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

OR Signature of Parent or Legal Representative: _____ Date: _____

Signature of Witness & Credentials/ Title Obtaining Telemedicine Consent: _____ Date: _____

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

Alabama Department of Mental Health
Office of Deaf Services

AltaPointe Health

Notification of Right to Free Language Assistance

(This form must be presented in a format the consumer can easily understand. This usually means the consumer's preferred language)

Verbiage should not be changed below this line.

I, _____, have been informed that it is important for my care to receive the services in the language that I understand best (my language of preference) and/or in a communication modality which is most readily understandable. I have been advised that the Department of Mental Health (DMH) is willing and can provide, at no cost to me, a clinical service provider who is fluent in my language of preference, a qualified professional interpreter, and/or appropriate accommodations. I have decided:

☐ I want to work with a clinical service provider fluent in my language of preference for direct clinical services. I understand that a qualified interpreter may be utilized when a clinical service provider fluent in my language of preference is not available.

☐ I want to work with a nationally certified and qualified interpreter.

☐ I prefer to use the following person to interpret for me: _____. I agree not to hold my clinical service providers, ADMH or its contract programs responsible for any adverse results that may arise from using this person as my interpreter. (This person cannot be a family member or other person younger than 18 years old.)

☐ I am a hard of hearing or a deaf person and want to work with a clinical service provider utilizing the following accommodations (***please specify below****):

☐ Oral Transliterater ☐ Cued Speech Transliterater

☐ Written English, which may include the following methods (CART, C-print, typed via computer, Ubi-Duo, voice recognition software, handwritten notes, access to written materials, etc.)

☐ Lip reading/speechreading/residual hearing with the following accommodations (preferential seating, maintained eye contact, reduced ambient noises, speech directed to better ear, increased volume, appropriate turn taking and identification of speaker, etc.)

***Please specify preferred accommodations as mentioned above**_____

☐ Other, please specify: _____

☐ I do not want free language/communication assistance provided by ADMH as mentioned above. I agree not to hold my clinical service provider or any other personnel at ADMH or its contract programs responsible for any adverse consequences that may arise as a result of my decision.

I understand that if my treatment team requests an accessibility accommodation provided by DMH, it will be provided for them. I also understand that I can change my mind at any time. This waiver will expire one (1) year from the date signed. I understand that I may change my selection at any time by completing a new waiver.

_____ Signature of Consumer

_____ Signature of Parent or Guardian (if applicable)

_____ Date

_____ Signature of Provider

_____ Signature of Staff or Interpreter fluent in preferred language of consumer. (if consumer's preferred language is not English)

Updated 11/2015, NB-65
Revised 4/23/2018

Note: If the consumer has indicated that he or she does not wish to take advantage of free language assistance, this refusal is to be documented in writing. Every effort should be made to assure that the consumer fully understands his or her right to accessible communication in their language of preference through a clinical service provider, fluent in their preferred language, an interpreter or other appropriate provider and that such assistance will be provided at no charge. A provider who does not share the preferred language of the consumer does not meet the standards of this notification. Pursuant to Title VI requirements this document is to be filed in the consumer's permanent file and a copy given to the consumer.

MR#:_____ Date:_____/_____/_____

Updated 02/2019

Alabama Department of Mental Health
Office of Deaf Services

AltaPointe Health

Notification of Right to Free Language Assistance

for Individuals Who Utilize a Spoken Language Other Than English

(This form must be presented in a format the consumer can easily understand. This usually means the consumer's preferred language)

Verbiage should not be changed below this line.

Case #_____ Provider/Center Name_____

I, _____, have been informed that it is important for my care to receive the services in the language that I understand best (my language of preference) and/or in a communication modality which is most readily understandable.

My language of preference is: _____

I have been advised that the agency is willing and can provide, at no cost to me, a clinical service provider who is fluent in my language of preference, a qualified professional interpreter, and/or appropriate accommodations. I have decided:

☐ I want to work with a clinical service provider fluent in my language of preference for direct clinical services. I understand that a qualified interpreter may be utilized when a clinical service provider fluent in my language of preference is not available.

☐ I want to work with a qualified interpreter. Vetting will be completed by the agency and documentation of the interpreter's qualification will be included in my permanent file.

☐ I prefer to use the following person to interpret for me: _____. I agree not to hold my clinical service providers, ADMH or its contract programs responsible for any adverse results that may arise from using this person as my interpreter. (This person cannot be a family member or other person younger than 18 years old.) The agency or the ADMH may determine that the person is not able or appropriate to perform this function. In such cases, the person mentioned above may remain as a support system.

☐ Other, please specify: _____

☐ I do not want free language/communication assistance provided by ADMH or its contract providers as mentioned above. I agree not to hold my clinical service provider or any other personnel at ADMH or its contract programs responsible for any adverse consequences that may arise as a result of my decision.

I understand that if my treatment team requests an accessibility accommodation provided by the ADMH or contract provider, it will be provided for them. I also understand that I can change my mind at any time. This waiver will expire one (1) year from the date signed. I understand that I may change my selection at any time by completing a new waiver.

_____ _____ _____

Signature of Consumer | Signature of Parent or Guardian (if applicable) | Date

_____ _____

Signature of Provider | Signature of Staff or Interpreter fluent in preferred language of consumer. (if consumer's preferred language is not English)

If the staff or interpreter providing the explanation of this document is in a remote location, their name or ID number, contact information, and language credentials are listed below:

Name/ID #: _____ Contact information: _____

Language and/or Interpreting Credentials: _____

Note: If the consumer has indicated that he or she does not wish to take advantage of free language assistance, this refusal is to be documented in writing. Every effort should be made to assure that the consumer fully understands his or her right to accessible communication in their language of preference through a clinical service provider, fluent in their preferred language, an interpreter or other appropriate provider and that such assistance will be provided at no charge. A provider who does not share the preferred language of the consumer does not meet the standards of this notification. Pursuant to Title VI requirements this document is to be filed in the consumer's permanent file and a copy given to the consumer.