

## Pre-Intake

Today's Date: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_  
First Middle Initial Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> Preferred Communication: \_\_\_\_\_ DO NOT CONTACT

\_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_ Cell Phone: \_\_\_\_\_ Text: \_\_\_\_\_

\_\_\_\_\_ E-Mail: \_\_\_\_\_ Regular Mail: \_\_\_\_\_

Marital Status: (circle your response) Legally Married Never Married Separated (Legally or Otherwise Absent)  
Divorced Widowed Common Law/Cohabiting

Language of Preference: (circle your response) English ASL French Spanish Laotian Other (specify): \_\_\_\_\_

Race: (circle your response) Black/African American White/Caucasian Asian Alaskan Native American Indian  
Native Hawaiian/Other Pacific Islander More Than One Race Reported Other (specify) \_\_\_\_\_

Ethnic Origin: (circle your response) Not Hispanic Hispanic Cuban Mexican/Mexican American  
Puerto Rican Other Hispanic

Are you pregnant? \_\_\_ Yes \_\_\_ No

Hearing Status: (circle your response) Hearing Hard of Hearing Deaf Do you need an interpreter? \_\_\_ Yes \_\_\_ No

Place of Birth: (City, State and County) \_\_\_\_\_

Highest grade completed? \_\_\_\_\_

Employment Status: (circle your response) Full-Time Part-Time Disabled Unemployed Inmate of Institution  
Supported Employment Sheltered/Non-competitive Employment Not Looking for Work Student Retired  
Homemaker Not Applicable



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**ALTAPOINTE HEALTH  
STATEMENT OF UNDERSTANDING AND CONSENTS**

**PATIENT 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 patient (by mouth or injection) to prevent harm to themselves or others.

*Children and adolescent inpatient patients 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 patients 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 and other designated HIEs. I understand that any physician or hospital that participates in the 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 may choose to Opt-Out of allowing your health information to be shared through the 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, the patient (responsible person) hereby agrees to and guarantees payment of all AltaPointe charges incurred for the account of the patient 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 from 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:** Patient certifies that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the respective State Medicaid Agency or its intermediaries or insurance carries any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

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

\_\_\_\_\_ **Assignment of Insurance Benefits and Agreement to Pay Any Balance:** Patient (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 patient, for the payment of treatment and medical care being provided. Patient (responsible party) authorizes payment directly to AltaPointe Health of said medical reimbursement benefits. Patient (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, patient (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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**AltaPointe Health Statement of Understanding and Consents pg. 2**

\_\_\_\_\_ **No Surprise Billing:** I have been informed of my right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. The estimate is based on information known at the time the estimate was created and should complications or special circumstances occur, I could be charged more. If I am charged more, I have the right to dispute.

\_\_\_\_\_ **Integrated Healthcare Pharmacy Services:** As a patient 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 patient. It is the patient'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 patients 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 patient may damage or destroy.

\_\_\_\_\_ **Confidentiality of Information and Group Participation:** I understand that any information which is disclosed to me while I am a patient 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.

\_\_\_\_\_ **Patient Rights Statement:** I understand that AltaPointe subscribes to a Patient Rights Statement, which has been made available to me. I have had the opportunity to have the Patient 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 patient'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).

**Please refer to the Health Information Exchange section of this document for HIE information.**

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

\_\_\_\_\_ **Rehabilitation Act:** It is the policy of AltaPointe, in compliance with Section 504 of the Rehabilitation Act of 1973, 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 complaint with the Patient Relations Department, 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 patient 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:** Patient (responsible person) acknowledges and agrees that AltaPointe does not assume responsibility for any personal possessions. Patient and/or legal guardian acknowledges and agrees to accept responsibility for any personal possessions. Patient acknowledges and agrees to accept responsibility for clothing and/or personal effects including dentures, eyeglasses, hearing devices, etc.



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**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 patient health information for the purpose of improving patient 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 patient security and privacy.

**Expected Benefits**

- Improved access to psychiatric care by enabling a patient 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: \_\_\_\_\_

**BC 01023**

Revised 11/30/2022



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MR#:  EP:  Date:  -  -   
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**ALTAPOINTE HEALTH**

**INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION**

I, \_\_\_\_\_ hereby consent to the verbal/ email exchange of information between  
(Print patient name)

AltaPointe Health and: \_\_\_\_\_  
(Guardian Name, Email Address, and Phone Number which 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/ Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature (if appropriate)

\_\_\_\_\_  
Date

Revised: 11/30/2022  
BC 01004 - ACG



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**ALTAPOINTE HEALTH**

**INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION**

I, \_\_\_\_\_ hereby consent to the verbal/ email exchange of information between  
(Print patient name)

AltaPointe Health and: \_\_\_\_\_  
(School Name/ Contact Person or Email Address which 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/ Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature (if appropriate)

\_\_\_\_\_  
Date

Revised: 11/30/2022  
BC 01004- ACS



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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 are Deaf or Hard of Hearing

*(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. This information is included in my Communication Skills Assessment Report. I have been advised that the Alabama Department of Mental Health (ADMH) 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.) The agency or the ADMH Office of Deaf Services 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.

- 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 lighting, 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 the ADMH, 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)

This document is to be filed in the consumer's file. If the consumer does not have a file, this document is to be filed in the consumer's file. If the consumer does not have a file, this document is to be filed in the consumer's file. If the consumer does not have a file, this document is to be filed in the consumer's file.





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: \_\_\_\_\_

The consumer has indicated that he/she does not desire to receive any assistance or services from the provider and that he/she understands the consequences of his/her decision. Pursuant to Title VI requirements this document is to be filed in the consumer's file.



# SLIDING FEE DISCOUNT PROGRAM



## Sliding Fee Discount Program Application Instructions

Patients who are unable to pay for services at any of the AltaPointe Health Outpatient, BayPointe or EastPointe Hospitals, or Accordia Health locations, except for services rendered at Bayview Professional and Accordia Health & Wellness, may qualify for our Sliding Fee Discount Program (SFDP). The SFDP will cover all or a portion of the cost of care you receive. The amount of financial assistance received is based on income and household size following the Federal Poverty Guidelines.

To be considered for this program you must complete the attached application and provide one of the following to satisfy the proof of income requirement:

- Most recent income tax return with W-2(s) and/or 1099
- Most recent 2 pay stubs
- Earnings record from ssi.gov
- Proof of social security income, if applicable
- Proof of alimony, child support, unemployment, pension, etc.
- Other earning documents (provide to staff to be evaluated)

If you are unable to provide an acceptable form of proof of income, you may sign a self-attestation statement and are requested to provide one of the following documents for support of this statement:

- Verification letter if receiving food stamps
- Proof of family planning only, Medicaid
- If you receive no income and are being supported by relatives or friends, a letter explaining those arrangements is requested. The letter must be signed by person(s) lending assistance.

Once your application is completed, please return it and your proof of income documentation to any AltaPointe Health, AltaPointe Hospital or Accordia Health location, or mail it to:

AltaPointe Health Systems, Inc.  
5750-A Southland Drive Mobile, AL, 36693  
Attention: Practice Management Coordinator

AltaPointe Health, BayPointe or EastPointe Hospitals, or Accordia Health will review your application to determine the level of assistance for which you are eligible. Once a decision is made, you will be notified of approval or denial of the SFDP. If approved, the level of financial assistance received will be based on household size and income on the Federal Poverty Guidelines.

If approved, this application will be good for one year and will be used for all locations you are being served. The discounted amount will be valid at all AltaPointe Health Outpatient, BayPointe or EastPointe Hospitals, and Accordia Health, except for Bayview Professional and Accordia Health & Wellness locations. You will need to inform AltaPointe Health Outpatient, BayPointe or EastPointe Hospitals, or Accordia Health if there are any changes in your financial situation during the year that may impact your eligibility for this program. If you need any assistance with the application, please contact us in person or by phone at (251) 450-5916.



# SLIDING FEE DISCOUNT PROGRAM



## Discount Program Application

### Patient Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (MI) (MM/DD/YYYY)

Address: \_\_\_\_\_  
(Street/Apt Number) (City) (State) (Zip)

Social Security Number: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Home) (Cell)

### Parent/Guardian Information 1:

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (MI) (MM/DD/YYYY)

Address: \_\_\_\_\_  
(Street/Apt Number) (City) (State) (Zip)

Relationship to Patient: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Home) (Cell)

### Parent/Guardian Information 2:

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (MI) (MM/DD/YYYY)

Address: \_\_\_\_\_  
(Street/Apt Number) (City) (State) (Zip)

Relationship to Patient: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Home) (Cell)

### Household and Income (List all persons living in the household, including yourself):

	Name	Relationship	Age	Annual Income	Source
1					
2					
3					
4					
5					
6					
7					
8					



# SLIDING FEE DISCOUNT PROGRAM



**Self-Attestation Statement:** I am unable to provide any proof of income as described above and have discussed this with staff. I am agreeing to provide requested documents to support this statement. I understand this information will be used to determine my eligibility for the Sliding Fee Discount Program. By signing this section, I am stating that I am providing truthful, to the best of my knowledge, information, and I self- attest to the income (or lack of income) stated in the household/income section above.

Signature of Patient/Guardian: \_\_\_\_\_ Date signed: \_\_\_\_\_

Witness: \_\_\_\_\_ Printed Name: \_\_\_\_\_

I hereby request that AltaPointe Health Outpatient, BayPointe or EastPointe Hospitals, or Accordia Health to determine my eligibility for Sliding Fee Discount Program services. I hereby attest that I am not covered by any form of prescription insurance, nor am I covered by any form of government-sponsored health insurance, including Medicare, Medicaid, VA benefits, or other coverage.

I understand that the information, which I submit concerning my annual income and household/family size, is subject to verification by this organization and subject to review by state and/or federal enforcement agencies and others as required. I understand that the information given within this document is for the purpose of determining eligibility for the Sliding Fee Discount Program and that false or incomplete information will result in my disqualification for assistance.

If my financial situation changes in the upcoming year, I will report these changes to AltaPointe Health Outpatient, BayPointe or EastPointe Hospitals, or Accordia Health immediately.

Print Patient Name: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_ Date signed: \_\_\_\_\_

Witness: \_\_\_\_\_ Printed Name: \_\_\_\_\_

For Finance & Accounting Use Only:

Date Reviewed: \_\_\_/\_\_\_/\_\_\_ Approved  Denied

Reviewed by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_

AltaPointe Health Percentage: \_\_\_%

Accordia Health Slide: \_\_\_\_\_

Dispensary of Hope Eligible: Yes  Date: \_\_\_\_\_ No  Reason: \_\_\_\_\_

Patient/Guardian notified: Yes  Date: \_\_\_\_\_ No  Reason: \_\_\_\_\_

***\*All Practice Managers/Staff – Any patient unable to provide proof of income must be presented to the Practice Management Coordinator for review before a determination of discount can be applied.***





## **Patient Rights**

As a patient of Accordia Health / AltaPointe Health, you have the following rights:

- To be treated with respect, consideration, dignity and to receive high quality healthcare.
- To not be discriminated against in the delivery of healthcare services.
- To be assured of confidential treatment and to authorize the release of identifiable healthcare and other personal information.
- To review and receive copies of your medical records and/or request that your records be amended.
- To choose your healthcare provider.
- To be informed of your medical condition, treatment plan, and expected outcome.
- To receive accurate, easily understood information and to request assistance or be represented by parents, guardians, family members, or others in making informed healthcare decisions.
- To refuse treatment and refuse to participate in research.
- To be informed of the names, functions, and credentials of all persons providing service to you and to receive the names and telephone numbers of management.
- To be informed of available services, hours of service, and after hour coverage.
- To have a fair and efficient process for voicing grievances.

## **Patient Responsibilities**

As a patient of Accordia Health / AltaPointe Health, you have the following responsibilities:

- To give truthful and accurate information about your health and past medical treatment.
- To ensure that you fully understand and follow the treatment plan prescribed by your healthcare provider.
- To inform your healthcare provider of any changes in your condition or of any adverse reactions to the treatment plan.
- To keep appointments and inform the center in advance when you are unable to keep an appointment.
- To pay for services rendered in accordance with the fee policy and to provide truthful and accurate financial and/or insurance information to allow for appropriate billing.
- To become informed of and to follow health center rules and regulations concerning patient care and conduct.
- To participate in the management of my care and related activities.



## Procedure for Review of Records

Any patient or legal representative of a patient may request an opportunity to review his/her records to obtain information from his/her records at AltaPointe/ Accordia 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 patient's request and medical record to the clinician for determination if release of information would be detrimental to the patient.

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

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 or Two witness signatures with copy of identification.

### Appeal Process

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

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

Step 3: If you are not satisfied with the solution offered by the Patient Relations Committee you may request that your complaint, be reviewed by the CEO of AltaPointe/ Accordia 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:

Alabama Department of Mental Health -Advocacy Services  
1-800-367-0955

Alabama Disabilities Advocacy Program  
1-800-826-1675

Patient Relations Department  
(251) 450-4303

Department of Human Resources  
Mobile County (251) 450-7000  
General Information (334) 242-1310

Adult Protective Services (800) 458-7214/ Child Protective Services (334) 242-9500

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



## COMPLAINT OR GRIEVANCE PROCESS

You may report any complaint/grievance to any employee of AltaPointe/ Accordia Health. All complaints received will be reported to the Patient Relations Department.

- You will receive a response with possible solutions to your complaint within 10 working days from the Patient Relations Specialist.
- If you are not satisfied with the solution, you may request that your complaint be reviewed by the Patient Relations Department.
- You will receive a response with a possible solution from the Patient Relations Department within 10 working days.
- If you are not satisfied with the solution offered by the Patient Relations Department, 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.

Alabama Department of Mental Health-Advocacy Services  
(800) 367-0955

Department of Human Resources  
Mobile County (251) 450-7000  
General Information (334) 242-1310  
Adult Protective Services (800) 458-7214/ Child Protective Services (334) 242-9500

Alabama Disabilities Advocacy Program  
(800) 826-1675

Patient Relations Department  
(251) 450-4303

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe/ Accordia Health by either calling (800) 994-6610 or emailing [complaint@jointcommission.org](mailto: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 (800) 356-9596, Monday-Friday 8am-5pm.

If you call after 5 PM or on weekends you can leave a message.

## WHAT TO DO IF YOU HAVE A PROBLEM

1. If you don't like something that happens to you here, tell a grown up right away. Your parents can do this for you too.

We have someone called a Patient Relations Specialist who will talk to you and maybe your parents. She/he will try to find a way to fix the problem. She/he will tell you about her/his ideas in about 10 days.

2. If you don't like what she/he says you can ask the Patient Relations Department for help. They will try to come up with other ideas. They will let you know in about 10 days.

3. If you don't like what they say you can ask our Executive Director for help. He will let you know what he thinks in about 30 days.

You can always call someone at these numbers too:

Alabama Department of Mental Health -Advocacy Services  
(800) 367-0955

Alabama Disabilities Advocacy Program  
(800) 826-1675

Patient Relations Department  
(251) 450-4303

Department of Human Resources  
Mobile County (251) 450-7000  
General Information (334) 242-1310  
Child Protective Services (334) 242-9500

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

## **Summary of State Law Regarding Advanced Directives**

(Rule No. 560-X-28-.02 Summary of State Law Regarding Advanced Directives New Rule)

### **Deciding about your health care**

If you are 19 or older, the law says you have the right to decide about your medical care.

If you are very sick or badly hurt, you may not be able to say what medical care you want.

If you have an advance directive, your doctor and family will know what medical care you want if you are too sick or hurt to talk or make decisions.

### **What is an advance directive?**

An advance directive is used to tell your doctor and family what kind of medical care you want if you are too sick or hurt to talk or make decisions. If you do not have one, certain members of your family will have to decide on your care.

You must be at least 19 years old to set up an advance directive. You must be able to think clearly and make decisions for yourself when you set it up. You do not need a lawyer to set one up, but you may want to talk with a lawyer before you take this important step. Whether or not you have an advance directive, you have the same right to get the care you need.

### **Types of advance directives**

In Alabama you can set up an Advance Directive for Health Care. The choices you have include:

A living will is used to write down ahead of time what kind of care you do or do not want if you are too sick to speak for yourself.

A proxy can be part of a living will. You can pick a proxy to speak for you and make the choices you would make if you could. If you pick a proxy, you should talk to that person ahead of time. Be sure that your proxy knows how you feel about different kinds of medical treatments.

Another way to pick a proxy is to sign a durable power of attorney for health care. The person you pick does not need to be a lawyer.

You can choose to have any or all of these three advance directives: Living will, proxy and/or durable power of attorney for health care.

Hospitals, home health agencies, hospices and nursing homes usually have forms you can fill out if you want to set up a living will, pick a proxy or set up a durable power of attorney for health care. If you have questions, you should ask your own lawyer or call your local Council on Aging for help.

### **When you set up an advance directive**

Be sure and sign your name and write the date on any form or paper you fill out. Talk to your family and doctor now so they will know and understand your choices. Give them a copy of what you have signed. If you go to the hospital, give a copy of your advance directive to the person who admits you to the hospital.

### **What do I need to decide?**

You will need to decide if you want treatments or machines that will make you live longer even if you will never get better. An example of this is a machine that breathes for you.

Some people do not want machines or treatments if they cannot get better. They may want food and water through a tube or pain medicine. With an advance directive, you decide what medical care you want.

### **Talk to your doctor and family now**

The law says doctors, hospitals and nursing homes must do what you want or send you to another place that will. Before you set up an advance directive, talk to your doctor ahead of time. Find out if your doctor is willing to go along with your wishes. If your doctor does not feel he or she can carry out your wishes, you can ask to go to another doctor, hospital or nursing home.

Once you decide on the care you want or do not want, talk to your family. Explain why you want the care you have decided on. Find out if they are willing to let your wishes be carried out.

Family members do not always want to go along with an advance directive. This often happens when family members do not know about a patient's wishes ahead of time or if they are not sure about what has been decided. Talking with your family ahead of time can prevent this problem.

### **You can change your mind any time**

As long as you can speak for yourself, you can change your mind any time about what you have written down. If you make changes, tear up your old papers and give copies of any new forms or changes to everyone who needs to know.

### **For help or more information:**

Alabama Commission on Aging (800) 243-5463

Choice in Dying, (800) 989-9455

**Author:** William O. Butler, III, General Counsel

**Statutory Authority:** Alabama Medicaid Agency Administrative Code; Title XIX, Social Security Act; and §41-22-1 et seq., Code of Ala. 1975.

**History:** Rule effective October 1, 1982, June 17, 1988, October 7, 1988, October 12, 1988, January 10, 1989, July 13, 1991, March 13, 1992, January 13, 1993, and May 13, 1994.

**Amended:** Filed April 20, 1999; effective July 13, 1999.

# ADVANCE DIRECTIVE FOR HEALTH CARE

## (Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

### Section 1. Living Will

I, \_\_\_\_\_, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

#### **If I become terminally ill or injured:**

*Terminally ill or injured* is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

*Life sustaining treatment* – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

*Place your initials by either “yes” or “no”:*

I want to have life sustaining treatment if I am terminally ill or injured.     Yes     No

*Artificially provided food and hydration* (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either “yes” or “no”:*

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

Yes     No

## If I Become Permanently Unconscious:

*Permanent unconsciousness* is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

*Life sustaining treatment* – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

*Place your initials by either “yes” or “no”:*

I want to have life-sustaining treatment if I am permanently unconscious.     Yes     No

*Artificially provided food and hydration* (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either “yes” or “no”:*

I want to have food and water provided through a tube or an IV if I am permanently unconscious.  
 Yes     No

**Other Directions:** Please list any other things you want **done** or **not done**.

In addition to the directions I have listed on this form, I also want the following:

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*If you do not have other directions, place your initials here:*

No, I do not have any other directions.

## Section 2. If I need someone to speak for me.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

*Place your initials by only one answer:*

\_\_\_\_\_ I **do not** want to name a health care proxy. *(If you check this answer, go to Section 3)*

\_\_\_\_\_ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes.

**First choice for proxy:** \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day-time phone number: \_\_\_\_\_

Night-time phone number: \_\_\_\_\_

**If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:**

**Second choice for proxy:** \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day-time phone number: \_\_\_\_\_

Night-time phone number: \_\_\_\_\_

### Instructions for Proxy

*Place your initials by either "yes" or "no":*

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. \_\_\_\_ Yes \_\_\_\_ No

Place your initials **by only one** of the following:

\_\_\_\_\_ I want my health care proxy to follow **only** the directions as listed on this form.

\_\_\_\_\_ I want my health care proxy to follow my directions as listed on this form **and** to make any decisions about things I have not covered in the form.

\_\_\_\_\_ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

### Section 3. The things listed on this form are what I want.

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.
- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

\_\_\_\_\_  
\_\_\_\_\_

### Section 4. My signature

Your name: \_\_\_\_\_

The month, day, and year of your birth: \_\_\_\_\_

Your signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

## Section 5. Witnesses (need two witnesses to sign)

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 health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of second witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Section 6. Signature of Proxy

I, \_\_\_\_\_, am willing to serve as the health care proxy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Signature of Second Choice for Proxy:

I, \_\_\_\_\_, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PSYCHIATRIC ADVANCE DIRECTIVE**

Patient Name \_\_\_\_\_

MR # \_\_\_\_\_

If you are hospitalized for mental health care in the future and can't 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

Patient 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 care, 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(s): \_\_\_\_\_

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

Patient 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                   | _____ Medication in pill form   |
| _____ Physical restraints         | _____ Medication in liquid form |
| _____ Both seclusion & restraints | _____ Medication by injection   |
| _____ Other: _____                |                                 |

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: (Patient): \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_