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: _____

1st, 2nd and 3rd 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/Cohabitating

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

DHR Information:

Is client in DHR custody? ____ Yes ____ No **DHR County: _____**

Name of DHR Worker: _____ **Phone Number of DHR Worker: _____**

Guardianship: (circle your response) Legally Appointed Guardian DHR Custody DYS Custody DMH Custody None

Legal Status: (circle your response) Voluntary Not Guilty by Reason of Insanity Juvenile Court

Involuntary Civil-Outpatient Involuntary Civil-Inpatient Other Court Ordered

Veteran Status: (circle your response) Not a Veteran Currently on Active Duty Previously on Active Duty

Military Dependent

Individual Annual Income: $_____

Total Household Annual Income: $_____

Primary Source of Income: (circle your response) Wages/Salary Public Assistance (i.e. Food Stamps/TANF)

Retirement/Pension Disability (SSI, SSDI) None Other (specify) _____

Do you have insurance? _____ Yes _____ No

Expected Payment Source: (circle your response) Self Worker's Compensation Commercial Insurance (BCBS, UHC)

Medicare Medicaid Medicare/Medicaid Other (specify) _____

Residential Arrangement: (circle your response)

Independent Living (adults only) Private Residence (children only) Homeless/Shelter Boarding Home

Jail/Correctional Facility Other Institutional Setting Foster Home Adult Foster Home Children

Crisis Residence Nursing Home DYS Group Home DHR Group Home

Assisted Living/Skilled Assisted Living Center Operated/Contracted Residential Program

Number Living in Household: _____

Client Living Arrangement: (circle your response) Alone Lives with Guardian Lives with Paid Care Provider

Unknown With Children With Non-Relatives With Other Relatives

Next of Kin:

Name: _____ **Relationship: _____**

Phone Number: _____

Emergency Contact:

Name: _____ **Relationship: _____**

Phone Number: _____

MR#: ☐☐☐☐☐☐ EP: ☐☐ Date: ☐☐ – ☐☐ – ☐☐☐☐
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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.

MR#: EP: Date: M M – D D – Y Y Y Y

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 l973, 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 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.

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
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AltaPointe Health Statement of Understanding and Consents pg. 3

_____ **Consent to Text**: I consent to receiving automated text alerts from AltaPointe on my mobile phone. Text alerts may be about appointments, test results, surveys, healthcare outreach, and more.

_____ **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.

_____ **Infection Prevention and Control Training:** I have received training on Infection Prevention and Control and had an opportunity to ask questions.

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 patient 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 $900 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 patient 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, birthdate, 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 advance directive and have been provided information by AltaPointe.

_____ **Consent for Sex education**: State and National Guidelines for child/adolescent treatment facilities require that the patients be offered the chance to participate in sex education classes. AltaPointe will offer these classes on an informational level to those patients 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 patient at AltaPointe. **(24-hour care programs)**

_____
Print Patient's Name | Patient's Signature | Date

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

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

If patient signature is not present mark reason:
_____ Patient Unable to Sign _____ Patient refused to Sign (Show multiple attempts)
Date: _____ Date: _____
Date: _____Date: _____

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
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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: _____

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 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

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 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

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)

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.

Updated 01/2024

Alabama Department of Mental Health
Office of Deaf Services

Notification of Right to Free Language Assistance

for individuals who are 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, _____, am a Hard of Hearing individual who may use English in an atypical format (such as lipreading, captioning, written format, etc.). I do not use sign language as my primary mode of communication.

**If sign language is utilized as a preferred/primary mode of communication, see NOFLA for Deaf form.*

**If a language other than English is utilized as a preferred/primary mode of communication, see NOFLA for Spoken Language*

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 Alabama Department of Mental Health (ADMH) is willing and can provide, at no cost to me appropriate accommodations. I have decided:

☐ 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****):

☐ 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**_____

_____

☐ Oral Transliterator

☐ Cued Speech Transliterator

☐ 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.)

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

_____

☐ Other, please specify: _____

☐ I am a Hard of Hearing individual and I prefer to use the following person to provide accommodations for me as indicated above: _____. 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. (This person cannot be a younger than 18 years old, this includes family members.) 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 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	Witness

Note: Every effort should be made to assure that the consumer fully understands his or her right to accessible communication in their language of preference 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.

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.

Revised 1.26.2022

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					

Revised 1.26.2022

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:

Approved ☐ Denied ☐

Date Reviewed:____/___/____

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 <u>proof of income</u> must be presented to the Practice Management Coordinator for review before a determination of discount can be applied.

Children's Outpatient Program Admission Agreement

AltaPointe uses a treatment team model that may consist of therapists, nurses, case managers, psychiatrist and/or a nurse practitioner. Our mental health treatment team will listen to you and your family, and provide a variety of supportive services.

We provide one or more of the following services:

- Individual Therapy
- Family Therapy
- Group Therapy
- Psychiatric Evaluation and Medication

During the services above, we will:

- Discuss how to help you and your family succeed
- Help you manage behavioral and/or emotional issues

What you need to know about Psychiatric Evaluation and Medication

- If needed, your therapist will make a referral for a psychiatric evaluation to see if medication may be helpful.
- A psychiatric evaluation is usually not recommended until you have attended at least **3 sessions.**
- The most effective approach for children and adolescents with behavioral and emotional issues is often a personalized treatment plan that may incorporate therapy and other supports, such as medication tailored to their individual needs.
- Therefore, our Psychiatrist or Nurse Practitioner may decide to discontinue use of medication if your child is not attending therapy.

What you need to know about canceling/rescheduling your appointments.

- For appointment rescheduling please call our receptionists at 251-450-2240. Please cancel/reschedule your appointment with our receptionists in advance whenever possible.
- If you do not attend therapy for more than 90 days, your record may be closed.

We look forward to working with you and your family.

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 evaluation

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 Accordia Health / 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:

Accordia Health / AltaPointe Health are 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 clinician 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 Patient Relations Specialist at 251-450-4303.
If you believe your privacy rights have been violated, you can file a complaint with the Patient Relations Specialist at Accordia Health / AltaPointe Health or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Your written statement to Accordia Health / 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

Patient Relations Specialist
Accordia Health / 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 (fox 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 includes 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 patients, 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 LOBBY OF THE FACILITY.

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.

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

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.

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:

_____

_____

_____

_____

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 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(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
___ 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: (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: _____/_____/_____