Print

Packet for Consent to Treatment

Referred Client: _____

Parent/Guardian Name: _____

Best Contact Number: _____

Email Address: _____

Consumer Profile

Consumer Name: _____ DOB: _____

Gender: _____ **Male** _____ **Female** Race: _____

Name of School: _____ Grade: _____

Name of Employer: _____ Position: _____

Insurance Type: _____ Policy ID #: _____

Home Address: _____

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Source of Referral: _____

EMERGENCY CONTACT NAME: _____

Phone: (_____)_____ Relationship: _____

Address: _____

Do you have concerns with Family360, Inc. telephoning you at home or sending mail to your home? ☐ Yes ☐ No Consumer Comments: _____

If the answer is YES, complete information below:

Can letters, which identify our facility (Family360, Inc.) be sent to this address: ☐ Yes ☐ No

Is there an alternative phone number to be used for communication? ☐ Yes ☐ No

Can our staff/ facility leave a message at this phone number? ☐ Yes ☐ No

Can this message include the name of our facility/staff? ☐ Yes ☐ No

Can we leave a blind message with our phone number only? ☐ Yes ☐ No

Have you ever receive any Mental Health and or substance abuse services? ☐ Yes ☐ No

Name of Institution: _____ Contact Person: _____

Phone#: (_____)_____ Service Dates: _____ Last Visit: _____

Any previous hospitalizations? ☐ Yes ☐ No (If "yes") where _____

When: _____ For how long: _____

What are the clients & family's expectation & preferences for this service? _____

_____

Any History of Mental Problem? ☐ No ☐ Yes _____

Criminal/Legal History? ☐ No ☐ Yes _____

History of DJJ involvement: ☐ No ☐ Yes _____

Medical History/Present medical concerns? ☐ No ☐ Yes _____

List Current Medication(s): _____

Name & Number of current Psychiatrist/PCP: _____

History of trauma (experienced and/or witnessed): ☐ No ☐ Yes _____

Spiritual beliefs/Church affiliation: ☐ No ☐ Yes ☐ N/A (If yes, please explain) _____

2004 Eastview Parkway, STE 110
Conyers, Georgia 30013
(678) 571-1197
(678) 806-4876
www.family360center.com

School Observation Form

As the parent/guardian of _____ I, _____ hereby give permission for Family360, Inc. to observe my child in the classroom. The observation will be at _____ School. In addition, I give Family360, Inc. permission to provide any additional support to my child as needed at school.

Print parent/guardian name: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Witness: _____ Date: _____

List of Staff Member Authorized to Observe and Provide Services to Client:

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Addictive Behaviors

Do you currently use alcohol or substance? ☐ Yes ☐ No

Substances Used	Age of Onset	Current Use?	Amount	Method of Use (oral, smoking, IV)	Date of Last Use	Frequency of Use
Alcohol						
Opioids						
Methadone						
Tranquilizers						
Sedative						
Cocaine						
Stimulants						
Marijuana						
Hallucinogens						
Inhalants						
Nicotine						
Caffeine						
Other:						

Acknowledgement of Freedom of Choice

I _____ have voluntarily enrolled in Mental & Behavioral Health Services provided by Family360, Inc. I understand that I have the right to select the provider of my choice. I have, of my own free will selected Family360, Inc. as my Mental Health Services provider.

Consumer's Signature: _____ **Date:** _____

Parent/Guardian Name: _____ **Date:** _____

CONSENT FORMS

CONSUMER AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Family360, Inc (the agency) and its employees or designees. I authorize the mental and behavioral services deemed necessary or advisable to address my needs, which encompasses but not limited to, comprehensive assessment, individual therapy, martial counseling, family therapy, group therapy, child/adolescent therapy, crisis intervention, case management services, psychiatric evaluation and psychiatric treatment referrals, psychological testing and psychological treatment referrals.

I agree to participate in a comprehensive assessment as part of the initial phase of treatment, and I agree to provide to the best of my knowledge, accurate and complete information about past medical issues, medication, hospitalizations and other matters relating to my health and well being.

I understand that I can decide to not participate in treatment provided by Family360, Inc by not signing the Treatment Plan which will be developed with my therapist following the Assessment phase of treatment.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Family360. I authorize the agency to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Agency may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to be made directly to the Agency for insurance benefits payable to me. I understand that I am financially responsible to the Agency for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees.

PRIVACY POLICY. I acknowledge having received the Agency's "Notice of Privacy Policies". My rights including the right to see and copy my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Agency has already made disclosures with my prior consent.

Client's Signature _____ **Date**_____

Parent/Guardian Signature **(if applicable)** _____ **Date**_____

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO PARTICIPATE IN TREATMENT AS OUTLINED.

I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION

Print Client Name Date of Birth	Print Parent or Guardian Name (if applicable)
Client Signature Date	Parent/Guardian Date (A copy of the guardianship "Letters of Office" from the court or custodial agreement is required.)
Witness Signature Date	

The rights have been explained to the client. To the best of my knowledge the client understands these rights.

Staff Signature Date

CONSUMER GRIEVANCE INSTRUCTIONS

1. If you have a concern or grievance, we encourage you to bring our concern grievance to the attention of the staff person involved. The staff person will address your concerns and attempt to solve the problem with you.

2. If you are unable to complete the first step or if your concern or grievance has not been resolved by meeting with the staff person concerned, you may request an interview with that staff person's immediate supervisor. This request may be made in writing, by telephone contact or in person to the Program Director of Clinical Director. Upon receipt of the request, the supervisor will contact you within 48 working hours.

3. If your concern or grievance is still not resolved to your satisfaction, you may re-contact the supervisor involved and request a mediation session with the assistance of a trained mediator, both parties can try to reach a mutually satisfactory resolution.

4. If you choose not to have a mediation session, or it does not resolve the issues, you may have a Review Hearing. The Review Hearing will be scheduled within 15 working days of your request. You may have an advocate or supportive person with you. We will keep minutes and provide you with a written response with 5 working days of the meeting.

   By signing, I acknowledge my understanding of the grievance instructions and Family360, Inc. no reprisal policy that states I will not be acted out against in retaliation for filing a grievance.

   Consumer/Guardian Signature: _____ Date: _____

   Witness Signature: _____ Date: _____

CLIENT ORIENTATION CHECKLIST

The following has been explained to me:

_____ Consent for treatment
_____ Identification of the person responsible for service coordination
_____ Nature and purpose of treatment
_____ Possible consequences, complications and/or risks to treatment
_____ Provision to individual of their rights as clients
_____ Provision to individual of the Family360's grievance procedure
_____ Explanation regarding the processes of assessment, treatment planning, treatment, transitional and discharge planning referrals, and follow-up.
_____ Explanation of Family360's comprehensive services and activities
_____ Hours of operation
_____ Access to after-hour services
_____ Code of ethics followed by all staff.
_____ Confidentiality policy: staff/clients
_____ Explanation of financial obligations, fees for services, and other Financial arrangements appropriate
_____ Exclusion of restraint or seclusion practices
_____ Prohibition of smoking anywhere in the main building or annex.
_____ Explanation of policy on using or bringing illicit or licit drugs onto the premises
_____ Explanation of policy on coming to services under the influence
_____ Explanation of policy regarding weapons brought on to the premises
_____ Explanation of expectations regarding keeping scheduled appointments and consequences of not doing so regarding further scheduling with therapist and/or paraprofessional
_____ Explanation of policy regarding review of file materials or gaining copies from file
_____ Explanation of input regarding satisfaction with services
_____ Explanation of exclusionary criteria
_____ Explanation of procedures to be re-admitted into the program
_____ If ordered into treatment by court, you are expected to appear at court when ordered; any violation must be reported to court which could lead to dismissal and punishment as court sees fit
_____ Identification of therapeutic interventions, including: sanctions, interventions, incentives, and administrative discharge criteria
_____ Notification of late cancellation/fail policy

I have been given a copy of:
_____ A statement of my rights as a client (Confidentiality)
_____ Grievance procedure/Violation of Client Rights and they have been explained to me in a language that I understand

I understand that Family360 operates under a Code of Ethics for Professional Behavior and that a copy of this document is available to me if I request one.

I give my permission to Family360 to contact me to participate in a *Quality Assurance Questionnaire*.
_____ Yes
_____ No

I understand the person responsible for coordinating services for me is:

_____, whose credentials have been explained to me.

THE ABOVE INFORMATION HAS BEEN EXPLAINED TO ME AND I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Client Signature Date of Birth Print Client Name

_____ _____
Parent Signature Date Print Parent Name

_____
Signature of Witness Date

CLIENT RIGHTS

You Have the Right:

1. To be free of discrimination or prejudice in receiving treatment regardless of age, gender, race, religion, sexual orientation, national origin, physical situation, psychological characteristics or religious and spiritual beliefs.
2. To have services that are responsive to your age, gender, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation and spiritual beliefs.
3. To receive treatment and services regardless of the source(s) of financial support.
4. To individualized treatment.
5. To be involved in the assessment and development of the Treatment Plan and to discuss any aspect of your treatment with your counselor.
6. To treatment in the least restrictive environment.
7. To have all information about you and your treatment to be held in strict confidence in accord with the state, federal and agency regulations and laws on confidentiality. You have a right to be protected in accordance with Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). The rights on confidentiality is governed by DBHDD and by the Health Insurance Portability and Accountability Act of 1996, HIPAA. Agency Staff are mandated reporters for DFCS & Elder Abuse.
8. To be informed about the nature of your care, procedures and treatment received in understandable terms.
9. To be informed about all possible consequences and benefits of all medications and treatment procedures used, and to give a written consent for treatment and a copy of the treatment plan.
10. To examine and receive an explanation of your bill, regardless of source of payment.
11. To stop treatment whenever you wish and to be informed of the consequences resulting from a refusal of treatment.
12. To be given help in meeting your continuing emotional and physical requirements upon case closing.
13. If you are 14 to 17 years of age, you are entitled to active participation in treatment and have up to five counseling sessions without parent or guardian knowledge or consent. Consent of treatment becomes necessary by law after five sessions.
14. To treatment free from any forms of abuse or retaliation, including psychological abuse, sexual abuse, punishment, neglect, harassment, humiliation, threats, fiduciary abuse and exploitation.
15. To receive considerate and respectful care.
16. To not be "abandoned" in treatment.
17. To not be denied, suspended, or terminated from services or have services reduced from exercising any of your rights.
18. To confidentiality of HIV antibody and/or AIDS status.
19. To know the name of the person coordinating your care.
20. To have the opportunity to evaluate the agency's service.
21. You have the right to receive Crisis Services.
22. You have a right to request a copy of the agency Code of Ethics and Professional Behavior.
23. You have the right to file a grievance up to the level of the Executive Director.
24. You have the right to informed consent.
25. You have a right to access your own lawyers or have referral information to access legal entities.
26. You have a right to go to advocacy/self help groups.

27. You have a right to refuse services from the person or service delivery team you get assigned and a right to request a specific clinician, if available, and referral given if preferred or appropriate
28. You have a right to information in sufficient time for decision making.
29. You have the right to access your records according to agency policy
30. You have a right to refuse concurrent or dual treatments for multiple problems
31. You have a right to not complete releases of information and right to revoke them, if already completed.
32. You have a right to an investigation and resolution of any alleged infringement of rights with in specific time frames. You will not face retribution or retaliation if you act in good faith in making a report
33. You have the right to contact a public payor (Department of Human Services, Department of Children and Family Services, Department of Rehabilitative Service and Department of Alcoholism and Substance Abuse)
34. To a description of the route of appeal available when you disagree with a facility's policies or procedures. You have the right to contact the Guardianship and Advocacy Commission and Equip for Equality if you feel your rights are being violated.
35. Family360 does not do human subject research.

Family360, Inc.
2004 Eastview Parkway, STE 110
Conyers, Georgia 30013
O: 678-571-1197
F: 678-806-4876
www.family360center.com

ALL RIGHTS SHALL BE PROTECTED IN ACCORDANCE WITH THE GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE .

I HAVE EXPLAINED THE ABOVE RIGHTS TO CLIENT AND IT IS MY BELIEF THAT THE CLIENT HAD UNDERSTOOD THESE RIGHTS.

CLIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Consumer: _____ Date: _____

Date of Birth: _____ ID#: _____

Releasing Agency: _____

Person Requesting Information: _____

Address: _____

City: _____ State: _____ Zip: _____

To obtain information from: _____

Address: _____

City: _____ State: _____ Zip: _____

The following type(s) of information from my records (and any specific portion thereof):

_____

_____

For the purpose of: _____

_____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

☐ Ninety (90) cays unless I specify an earlier expiration date here: _____

☐ One year from the date of this release

☐ The period necessary to complete all transactions on accounts related to services and treatment provided me.

_____ _____

Signature Consumer/Responsible Party Date

_____ _____

Signature of Witness Date

USE THIS SPACE ONLY IF CONSUMER WITHDRAWS CONSENT

_____ _____

Date Consent Revoked Consumer/Responsible Party

AUTHORIZATION TO TRANSPORT

(Personal Vehicle)

I_____ hereby request and authorize Family360, Inc.'s Team to transport _____ as needed to and from any planned activities. I understand that this authorization will remain in effect for the duration of Mental & Behavioral Health Services provided by Family360, Inc. I acknowledge that transportation is voluntary and during transportation the staff member will not knowingly or intentionally place my minor child, adult or myself in danger and will notify or seek emergency assistance if unforeseen circumstances occur that require any such public emergency official services.

I understand this agreement and that I may withdraw my consent at any time (in writing) by informing the Family360, Inc. staff and signing below.

_____ _____

Parent/Client/Guardian Signature Date

_____ _____

Witness Date

The Family360, Inc. employees and contractors have submitted the following items:

- Proof of Insurance
- Motor Vehicle Report (MVR)
- Valid Driver's License

Use this space only if Parent/Client/ Guardian withdraws consent

_____ _____

Signature of Consumer/Guardian Date