CLIENT CONTACT INFORMATION

Name: ______________________________________

Address:_____________________________________

____

Phone:______________________________________

Cell Phone (If different):________________________

Emergency Contact Name:______________________

Relationship:_________________________________

Contact Number:______________________________

Car make and model:___________________________

Vehicle tag number: ____________________________

Signature
PSYCHIATRIC HOSPITAL

PLACE PATIENT LABEL HERE

OUTPATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT
The undersigned authorizes Signature Psychiatric Hospital, its staff, and attending physicians to render to the patient all customary care, therapy, treatment, medications, tests and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is also given for any diagnostic procedures, medical treatment, x-ray treatment, recreational activities and therapy, and other treatment ordered by Signature Psychiatric Hospital and/or attending physicians including but not limited to services provided by other Healthcare Professionals to the patient.

The undersigned acknowledges that the patient is under the control of an attending physician(s) and Signature Psychiatric Hospital is not liable for any act or omission in following the instructions of said physicians. The undersigned recognizes that certain healthcare professionals furnishing services to the patient, including, but not limited to, radiologists, pathologist, psychiatrists, psychologists, physical therapists and/or licensed social workers may be independent contractors and may not be employees or agents of Signature Psychiatric Hospital. **The undersigned further recognizes that the patient may be billed separately by their attending physicians and/or other healthcare professionals for their services provided.**

CONSENTS FOR ADMISSION
The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, as to the results of any services provided to the patient, including but not limited to therapy, treatment, tests or procedures, while admitted to Signature Psychiatric Hospital. The undersigned further understands that, unless otherwise disclosed, Signature Psychiatric Hospital does not employ physicians and that the patients admitting physician(s) and any other physician who may consult or provide services to the patient during this admission are not employed by and are not agents of Signature Psychiatric Hospital, but are independent physicians who exercise their judgment in the services they render to patients.

RESPONSIBILITY FOR DESTRUCTION OF PROPERTY
The undersigned understand(s) that patients are responsible for any damage to or destruction of hospital property, or property belonging to others which may be located at the hospital. The undersigned agree to accept liability for, and reimburse the hospital or other owners of property that the patient may damage or destroy.

GUARANTEE OF PAYMENT
The undersigned, hereby agree(s) to guarantee the payment of the bill for services rendered by Signature Psychiatric Hospital. The undersigned agree(s) whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of the Hospital in accordance with the regular rates and terms of Signature Psychiatric Hospital. Should the account be referred for collection by an attorney or collection agency, The undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due.

ASSIGNMENT OF INSURANCE BENEFITS
In consideration of hospital and medical services rendered or to be rendered by Signature Psychiatric Hospital, to the extent permitted by law, I hereby (I) irrevocably assign, transfer and set over to Signature Psychiatric Hospital (II) all of my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issue in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Signature Psychiatric Hospital during the pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Signature Psychiatric Hospital to pursue any such right of recovery. I hereby authorize the insurance company(ies) or third party payor(s) to pay directly to Signature Psychiatric Hospital all benefits due for services rendered.

DISCHARGE POLICY INFORMATION
The undersigned understands that it is the policy of Signature Psychiatric Hospital to attempt to provide a structured therapy regimen with effective quality treatment. If the treatment regimen is not completed prior to the exhaustion of patient's health insurance benefits, the undersigned agrees to be liable for any charges incurred which are not paid by insurance in addition to the deductible and/or co-payment liability. It is NOT hospital policy to discharge or transfer patients or end treatment regimens simply because insurance benefits have been exhausted.

Policy Reference: OP.001

DO NOT WRITE BELOW THIS LINE

00S00

CONSENT FOR TREATMENT

Signature
PSYCHIATRIC HOSPITAL

PLACE PATIENT LABEL HERE

OUTPATIENT CONSENT FOR TREATMENT

CONSENTS FOR RELEASE OF INFORMATION **OUTPATIENT**

The undersigned authorizes Signature Psychiatric Hospital to release all patient information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Signature Psychiatric Hospital, to any insurance company, and/or third party payers, or representative providing coverage for this admission, or to any Signature Psychiatric Hospital representative including, but not limited to Signature Psychiatric Hospital employees, attending physicians, other healthcare professionals or organizations. This information may not be released to any other person or entity unless the undersigned so authorizes.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released.

The undersigned further authorizes Signature Psychiatric Hospital to release information for the purpose of obtaining pre-authorization for hospitalization and concurrent review and to release that information to medical review agencies, and/or third party payors providing coverage or having responsibility for this admission.

The confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations. Generally, Signature Psychiatric Hospital may not disclose information to anyone outside of Signature Psychiatric Hospital which would IDENTIFY any patient as an alcohol or drug abuser unless the patient has consented in writing; the disclosure is allowed by a court order, or the disclosure is made to medical or other qualified personnel in accordance with Federal regulations.

Federal law and regulations do not protect information regarding a crime or a threat to commit a crime or any information regarding suspected child abuse or neglect from being reported to appropriate State or local authorities. The undersigned also hereby authorizes free exchange of medical record information, including but not limited to the release of patient information indicated above, between Signature Psychiatric Hospital and the attending physician, his/her group practice association and/or other health care agencies, facilities and/or professionals, which may provide services to patient during this admission. This includes the authorization to discuss the patient specific information indicated above with the Referral Agency identified below:

Referral ___________________________ Address ____________________________________

Staff _____________________________ Phone: _________________________

The undersigned acknowledges their right to receive a copy of these Consents for Release of Information, and to inspect and/or copy the information to be disclosed. The undersigned acknowledges that this authorization shall be valid for at least 60 days following discharge or until all third party payers liability is resolved for this admission, whichever is later.

ADVANCE DIRECTIVE ACKNOWLEDGMENT

The undersigned acknowledges the following: _______ ***(Patient Initials)***

- I have been given written materials about my right to accept or refuse Medical Treatments.
- I have been informed of my rights to formulate Advance/Psychiatric Directives.
- I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.
- I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

☐ **I HAVE** ☐ **HAVE NOT** executed an Advance/Psychiatric Directives.

A copy of the patient's Advance Directive ☐ **HAS** ☐ **HAS NOT** been provided for inclusion in the patient's record.

APPLICABILITY TO OTHER PROVIDERS:

The undersigned agree(s) that in the event other healthcare professional providers, including but not limited to other hospital(s), furnish services to the patient while in Signature Psychiatric Hospital, the consent(s), assignment(s) guarantee(s) and release(s) herein above set out shall apply to such other providers and services.

Patient's Name	Patient's Signature	Date	Admission Time
Signature of Insured/Guarantor	Date	Signature of Insured/Co-Guarantor	Date
Signature of Legal Guardian – Next of Kin (For minor or incompetent patient)	Date	Signature Psychiatric Hospital Staff	Date

Policy Reference: OP.001

DO NOT WRITE BELOW THIS LINE

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CONSENT FOR TREATMENT

Signature
PSYCHIATRIC HOSPITAL

Authorization for Use or Release of Information Comprehensive

PLACE PATIENT LABEL HERE

I, ____
(Name of Patient)

____
(Date of Birth) (Social Security Number)

hereby authorize Signature Psychiatric Hospital to use or release specified confidential medical, psychiatric (including alcohol and/or drug), HIV/AIDS test results or diagnoses, and/or educational information obtained in the diagnosis and treatment at the hospital to the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information.

REFERRAL SOURCE

____
(Name) (Address) (City) (State) (Zip)

____
(Area Code) (Phone Number)

Purpose: To aid in the success of treatment, to provide continuity of care.

EMPLOYER

____
(Employer Name) (Address) (City) (State) (Zip)

____
(Area Code) (Phone Number)

Purpose: For verification of admission and stay in the hospital and/or insurance coverage benefits.

Information to Use or Disclose: ☐ Admission/Discharge Dates ☐ Admitting Diagnosis ☐ UDS
☐ Other ____

FAMILY PHYSICIAN

____
(Name) (Address) (City) (State) (Zip)

____
(Area Code) (Phone Number)

Purpose: To aid in the success of treatment, to provide continuity of care.

DFS/DCFS

____
(Name) (Address) (City) (State) (Zip)

____
(Area Code) (Phone Number)

Purpose: To aid in the success of treatment, to provide continuity of care.

Information to Use or Disclose: ☐ Admission/Discharge Notification ☐ Psychiatric Evaluation ☐ UDS
☐ Psychological Testing (if done) ☐ Discharge Summary ☐ Aftercare Plan ☐ Other ______________________

DO NOT WRITE BELOW THIS LINE

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ROI

Signature PSYCHIATRIC HOSPITAL

Authorization for Use or Release of Information Comprehensive

PLACE PATIENT LABEL HERE

OUT PT THERAPIST/PSYCHIATRIST

(Name) **(Address)** **(City)** **(State)** **(Zip)**

Purpose: To aid in the success of treatment, to provide continuity of care.

(Area Code) **(Phone Number)**

FAMILY MEMBER

(Name/Relationship) **(Address)** **(City)** **(State)** **(Zip)**

(Area Code) **(Phone Number)**

Purpose: To aid in the success of treatment.

Information to Use or Disclose: ☐ Admission/Discharge Notification ☐ Progress reports ☐ Discharge planning ☐ Family counseling ☐ Other ______

SCHOOL

(School Name and Contact Name) **(Address)** **(City)** **(State)** **(Zip)**

(Area Code) **(Phone Number)**

Purpose: Coordination of services; educational planning.

Information to Use or Release: ☐ Discharge summary ☐ Admission/Discharge Notification ☐ Other ______

PHARMACY

(Name) **(Address)** **(City)** **(State)** **(Zip)**

(Area Code) **(Phone Number)**

Purpose: Medication Verification.

Information to Use or Disclose: Name and dosage of medications.

LEGAL/DJO

(Name) **(Address)** **(City)** **(State)** **(Zip)**

(Area Code) **(Phone Number)**

Purpose: Coordination of legal services. To aid in the success of treatment, to provide continuity of care.

Information to Use or Disclose: ☐ Admission/Discharge Notification ☐ Psychiatric Evaluation ☐ Psychological Testing (if done) ☐ Discharge Summary ☐ Aftercare Plan ☐ Other ______

OTHER

(Name) **(Address)** **(City)** **(State)** **(Zip)**

(Area Code) **(Phone Number)**

Purpose: ______

Information to Use or Release: ☐ Admission/Discharge Notification ☐ Psychiatric Evaluation ☐ Psychological Testing (if done) ☐ Discharge Summary ☐ Aftercare Plan ☐ Other ______

DO NOT WRITE BELOW THIS LINE

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ROI

Signature
PSYCHIATRIC HOSPITAL

Authorization for Use or Release of Information Comprehensive

PLACE PATIENT LABEL HERE

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The treatment dates covered by this authorization are from preadmission to discharge and claims resolution. This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Signature Psychiatric Hospital from all liability that may arise from the use or disclosure of medical records in reliance on this authorization. **If patient is a minor, both the patient and a parent or guardian needs to sign the authorization.**

- **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days, or upon final discharge, **whichever occurs later**, from the date this authorization is signed.
- **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
- **Refusal to sign:** I understand that I may refuse to sign this authorization and that Signature Psychiatric Hospital will not condition treatment, payment, or eligibility for benefits on whether I sign this authorization.
- **Certification:** I certify that I am (check whichever applies):
  - ☐ The patient, and the identification that I have provided is true and correct.
  - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.
    My relationship to the patient is that of: ______________________________________.
- **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
- **Copy:** I understand that I may receive a copy of this completed form.

_______________________________________ _______________________
(Patient Signature) (Date)

_______________________________________ _______________________
(Parent/Guardian/Personal Representative Signature) (Date)

_______________________________________ _______________________
(Witness) (Date)

DO NOT WRITE BELOW THIS LINE

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ROI

Notice of Acknowledgement of Receipt
Notice of Privacy Practice, Notice of Physician Ownership, and Notice of Physician Availability

By signing this document, I acknowledge that I have received a copy of Signature Psychiatric Hospital's Notice of Privacy Practices, Notice of Physician Ownership, and Notice of Physician Availability.

______________________	______________________	__________
Patient Name (Print)	Signature	Date

______________________	______________________	__________
Legal Guardian (Print)	Signature	Date

Patient Medical Record Number or Social Security Number________________________

Patient Birth Date____________________

HOSPITAL USE ONLY

Date acknowledgement received:____________________

Signature of Signature Psychiatric Hospital employee:____________________________

- OR -

Reason acknowledgement was not obtained (declined to sign):

____

____

Signature
PSYCHIATRIC HOSPITAL

OUTPATIENT
PATIENT INFORMATION SHEET

PLACE PATIENT LABEL HERE

FALL PREVENTION WHILE AT THE PROGRAM

PATIENT INFORMATION SHEET

What is "fall prevention"?

Fall prevention is the process of taking steps to prevent falls from occurring. The risk of falling increases when taking certain prescribed medications, with underlying medical conditions, and with age. The most common injuries related to falls include head injuries, wrist fractures and hip fractures.

What can I do to prevent a fall?

Some simple measures that you can take to prevent a fall from occurring are listed below:

- Use handrails on walls when available.
- Wear rubber-soled and low-heeled shoes that are comfortable and fit properly.
- Avoid wearing flip-flops or other types of sandals with straps.
- Avoid quick movements when changing positions.
- Progress slowly from "sit to stand to walk", especially if you experience dizziness.
- Talk to your physician or nurse about side effects of medications that may effect your coordination and balance.
- Push in chairs when you leave the table.
- Avoid walking on wet or icy sidewalks or surfaces alone. Get assistance!
- Attach a bike basket or plastic bag to your walker to carry items.
- Avoid reaching for far away objects.
- Report spills to staff immediately.
- Avoid bringing and carrying heavy tote bags and purses.
- Keep the walkways and floors between chairs and tables free from personal items, such as, bags or purses.
- Ask for assistance getting in and out of vehicles.

Patient Signature_________________________________ Date_______________

Staff Signature___________________________________ Date_______________

DO NOT WRITE BELOW THIS LINE

Signature
PSYCHIATRIC HOSPITAL

PLACE PATIENT LABEL HERE

OUTPATIENT GUIDELINES

1. All clients are expected to maintain confidentiality of what is said in the group. Respect and support others in your group.

2. You are expected to attend groups on time and remain in the groups for the scheduled duration. You are also expected to participate in the groups and to complete all treatment assignments.

3. Please use the phone during break time only. Cell phones should be turned off during groups.

4. Appropriate attire, including footwear is required. Please do not wear sunglasses inside.

5. All clients are expected to maintain good personal hygiene, including proper hand washing.

6. Eating is not permitted in the groups, but beverages are allowed.

7. You must leave at home any items that would be considered contraband, or could cause injury to yourself or others. This includes weapons, potential weapons, illegal drugs, alcohol and medications not needed for that day. Please keep valuables and excessive amounts of money at home.

8. The following behaviors are not acceptable; consequences will depend on the seriousness of the offense and may result in discharge from the program: physical aggression, destruction of property, stealing, profanity, verbal abuse or threats, sexual harassment or sexual behavior toward or between clients, use or possession of illegal drugs or alcohol while enrolled in the program.

9. You understand that you may be subjected to random urine drug screens.

Patient Signature:_______________________________________ Date:_________________

Staff Signature:____ Date:_________________

DO NOT WRITE BELOW THIS LINE

Signature
PSYCHIATRIC HOSPITAL

OUTPATIENT
PATIENT SELF ASSESSMENT

PLACE PATIENT LABEL HERE

What led you to seek treatment at this time?

____

____

Please check the box if you have been experiencing these symptoms within the last 2 weeks.

- ☐ I have been restless and irritable.
- ☐ Lately, I don't enjoy hobbies, leisure activities or time with family and friends.
- ☐ I'm sleeping more.
- ☐ I'm having trouble getting to sleep, or I wake up early and cannot get back to sleep.
- ☐ I find it harder to stay on a task. I feel less able to concentrate.
- ☐ My thinking seems slow or fuzzy. It's hard to make a decision.
- ☐ It's been hard to get motivated. It's hard to start or finish things I need to do.
- ☐ I have been anxious or worrying a lot.
- ☐ I have been feeling very sad.
- ☐ I have a hard time believing things will ever get better.
- ☐ I have been crying a lot.
- ☐ I feel a lot a grief about someone or something I have lost.
- ☐ I have been feeling that I'm not good enough, worthless or a failure.
- ☐ I feel like my mood has been up an down a lot.
- ☐ I have been feeling overwhelmed.
- ☐ People have commented on my mood or attitude lately.
- ☐ I'm having trouble managing my diabetes, hypertension or other chronic illness.
- ☐ I have nagging aches and pains that don't get better, no matter what I do.
- ☐ I have been eating more than I used to. My appetite has increased.
- ☐ I have been eating less or my appetite has decreased.
- ☐ I have been drinking alcohol or using drugs more than usual.
- ☐ I feel that my functioning in everyday life (work and my interactions with family and friends) is suffering because of these problems.
- ☐ I've thought about suicide.

What is your expectation for attending the program? What would you like to change or accomplish?

- ☐ I would like to learn ways to better handle my depressed mood.
- ☐ I would like to be able to be more assertive with people.
- ☐ I would like to have better control over angry feelings.
- ☐ I would like to be able to express my feelings better.
- ☐ I would like to learn how to reduce and manage stress.
- ☐ I would like to learn how to be less isolated and increase my support system.
- ☐ I would like to learn how to cope with grief.
- ☐ I would like to have better self-esteem.
- ☐ I would like to stop using drugs or alcohol.

Other____

____

____

Thank you for completing this questionnaire. Your input will help your primary therapist develop your treatment plan.

DO NOT WRITE BELOW THIS LINE

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SCALES ASSESSMENTS