**Enrollment**

Provider: Please check off each item you have included in your enrollment packet. If the item does not apply to this client please write N/A in the blank. Include this form when you submit your enrollment packet for billing.

Provider Name and credentials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check or N/A

\_\_\_ Permission for Treatment signature required

\_\_\_ Primary care physician form-required by all plans

\_\_\_ Payment Plan and Insurance Information-signature required.

\_\_\_ Releases as needed

The following information is to be given to the client.

\_\_\_ Mission Statement

\_\_\_ Health Information Privacy

\_\_\_ Quality Assurance Program

.

\_\_\_ Scan of front and back of each insurance card. This will ensure accuracy in billing.

\_\_\_ Assessment with treatment plan -Complete and signed by the provider

The following are tools that may be used to assess but are not required:

\_\_\_ The symptom checklist is a tool you may use but is not required. There are separate tools for adults and children.

\_\_\_ The medical information form is a tool to help obtain information for the evaluation. It may be used or omitted.

\_\_\_ Write a Client Contact Note documenting the “diagnostic evaluation session” (90791) (1 unit). (The code H0032 for treatment plan development may only be used for billing Medicaid funded plans.) Include start and end time of session on all notes and the client’s response to the evaluation and treatment plan recommendations.

**Permission for treatment/services**

Freedom of Choice
I understand that the choice of providers is my responsibility and right as the client or guardian.  I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider.  I also understand that I may at any time choose another provider for this service by notifying my current provider.

Informed Consent
I understand that participation in treatment does not guarantee anticipated outcomes.  I understand that there may be unintended results of treatment affecting the client and other family/household members.  I understand that providers are legally bound to report suspected abuse of the client or of other family members.  I also understand that the providers have a duty to warn any intended victim of a threat to harm.

Persons Participating in Home and Community Based Services
I understand that I am giving permission to include in the client’s treatment sessions any persons present in the home, school or community at the time of service.  This includes but is not limited to myself, parents, spouses, step-parents, paramours, siblings, children, extended family, household visitors, caregivers, playmates and classmates.  I also understand that I have the right to dismiss anyone from participating in a session at any time and that I have the right to exclude anyone from the ongoing treatment process by written notice to the provider.

Privacy Practices

I understand that Transformations adheres to the Health Information Privacy Act and I agree to these practices. I agree that this information has been made available to me for me review.

Responsibilities

I understand my responsibility is to: 1) provide accurate information and report any changes in client wellbeing, 2) to keep all appointments and to give 24 hour notice of a need to reschedule, 3) to maintain the client’s insurance coverage and report any lapse in coverage to the service provider, 4) to contribute to a plan of treatment and to follow through with agreed upon interventions.

Permission is hereby given to Transformations staff and its service providers to render screening, assessment, treatment and support services to the above named client and under the above named conditions.

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

Signature of Client

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

Signature of Parent or Legal Guardian Relationship to Client

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

Witness Date

Client and Payment Information

Client Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian name /address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foster parent/ address/phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am financially responsible for any services received. I agree to pay Transformations any co-pay, deductibles, and co-insurance agreed upon with my insurance company. *I give Transformations permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment.*

**PRIMARY INSURANCE: Provider must obtain a copy of both sides of all insurance cards**

\_\_ Medicare (always primary) \_\_\_ Private Insurance (primary over Medicaid) \_\_\_ Medicaid

Policyholder (if other than client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder address (if different from client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder's Employer (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # of Policyholder (if other than client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payor ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE:**

\_\_\_ Medicaid (secondary to other insurances) \_\_\_ Private Insurance (secondary to Medicare)

Policyholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder address (if different from client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder's Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # of Policyholder (if other than client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payor ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT PAYMENT RESPONSIBILITIES**

**Private pay agreement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Transformations accepts credit cards, checks, money orders and cash payments. Payment is expected at the time of service and arranged with your service provider.**

**Client or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization to Share Information With**

**Primary Care Physician**

**I understand that my records are protected under the applicable state law governing health care information that relates to mental health services, KRS 304.17A-555, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This Authorization to Share Information will automatically expire one year after the date of your signature.**

 **Transformations 4010 Dupont Circle Suite 582, Louisville KY 40207**

**Office Phone and Fax 502-899-5411 Email:** **office@transformationsllc.net**

**Select one:**

 **\_\_\_I give permission to my Physician and to Transformations to share any applicable information from my Protected Health Information including immunization, treatments, behavioral health treatment plans, recommendations and other health care records.**

**\_\_\_I do not give my Physician and Transformations permission to share my protected health care information.**

**Primary Care Physician Name, Address, Email Address & Fax Number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Patient or Guardian signature please date***

**---------------------------------------------------------------------------------------------------------**

Date of initial consult \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis or brief description of presenting problem

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Recommendations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Provider/credentials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Faxed or Mailed \_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO SHARE INFORMATION**

1. I authorize Transformations & its representatives & Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4010 Dupont Circle Suite 582 Contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Louisville KY 40207 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone & fax 502-899-5411 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secure email: office@transformationsllc.net \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the purpose of sharing this information is for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that I may revoke this authorization, at anytime, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.

4. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release

5. I understand that pursuant to KRS 304.17A-555-Patient’s Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

 6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child’s identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

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

 Consumer/Guardian if Client is under 18 Date

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

 Relationship to Client

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

 Witness Date

**AUTHORIZATION TO SHARE INFORMATION**

1. I authorize Transformations & its representatives & Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4010 Dupont Circle Suite 582 Contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Louisville KY 40207 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone & fax 502-899-5411 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secure email: office@transformationsllc.net \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the purpose of sharing this information is for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that I may revoke this authorization, at anytime, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.

4. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release

5. I understand that pursuant to KRS 304.17A-555-Patient’s Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

 6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child’s identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

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

 Consumer/Guardian if Client is under 18 Date

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

 Relationship to Client

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

 Witness Date

Screening and Mental Status Exam

**Symptoms Check List**: Please indicate what symptoms you are experiencing and the severity by making it with a number between 1 and 10 with 10 being the most severe.

**Activity: Sleep Disturbance**

\_\_\_\_Decrease in energy or fatigue \_\_\_Early morning waking

\_\_\_Hyperactivity \_\_\_Hyper-somnia

\_\_\_Impulsive \_\_\_Insomnia

\_\_\_Restless

\_\_\_Physically slowed **Memory/ Attention**

\_\_\_Physically agitated \_\_\_Easily Distracted

\_\_\_Excessive social, work, or playful activities \_\_\_Difficulty Concentrating

 \_\_\_Indecisive

**Behaviors:** \_\_\_Poor judgment

\_\_\_Work difficulties \_\_\_Memory loss

\_\_\_Aggressive

\_\_\_Violent **Thought and Speech**

\_\_\_Compulsions \_\_\_More talkative than usual

\_\_\_Dishonesty or theft \_\_\_Urge to keep talking

\_\_\_Destructive \_\_\_Racing thoughts

\_\_\_Disorganized \_\_\_Confused thinking

\_\_\_Oppositional or defiant \_\_\_Slurred speech

\_\_\_Reckless

\_\_\_Self-injurious **Perceptions and Thought Content**

\_\_\_Violation of the rules or rights of others \_\_\_Delusions

\_\_\_Legal problems \_\_\_Hallucinations (visual,sounds, touch,smells, etc.)

\_\_\_Bizarre or unusual thoughts

**Anxiety** \_\_\_Obsessive thoughts

\_\_\_Anxiousness \_\_\_Paranoid thoughts

\_\_\_Fear of separation \_\_\_Not feeling real/ depersonalization

\_\_\_Jitteriness \_\_\_Grandiose thoughts

\_\_\_Panic attacks \_\_\_Thoughts of suicide or death

\_\_\_Phobias \_\_\_Thoughts of a distressing event or flashbacks

\_\_\_Worry about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Eating Disturbances**

**Mood \_\_\_**Binge eating

**\_\_\_**Mood swings \_\_\_Loss of appetite

\_\_\_Angry \_\_\_Increase in appetite

\_\_\_Tearfulness \_\_\_Inability to maintain a stable body weight

\_\_\_Depressed mood \_\_\_self-induced vomiting

\_\_\_Excessive guilty

\_\_\_Elevated mood **Substance Use**

\_\_\_Feeling worthless Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Helpless \_\_\_Work or family conflict over use

\_\_\_Hopeless \_\_\_Inability to decrease use

\_\_\_Irritability \_\_\_Persistent desire for substance

\_\_\_Hostility \_\_\_An increase in tolerance

\_\_\_Loss of interests \_\_\_Withdrawal symptoms

\_\_\_Loss of pleasure or apathy \_\_\_Excessive time to obtain, use, or recover

\_\_\_Low self-esteem \_\_\_Legal problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider name, credentials, and date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Transformations hope for today’s families**

**Mission**

To promote mental, emotional, social, and behavioral health for adults, children and families.

**Values**

Supporting and sustaining families is fundamental to the healthy development of both children and adults. Children's needs are best addressed within their community setting. Parents are equal partners in decision making at every level. Greater progress and growth is achieved when strengths are acknowledged and interventions are designed to build on an individual's identified strengths. A cross-disciplinary team approach enriches creativity, problem-solving, and intervention. Collaboration among agencies creates enhanced resources, improved quality, and greater accountability in the community.

**Rights**

Clients and their families have the right to be treated with dignity and respect: Transformations does not discriminate on the bases of race, ethnic group, religion, gender, sexual orientation, political ideation, ability, educational level or previous life condition. You have the right to contribute to the goals, objectives, and interventions of your service plan. You have the right to complain and to expect resolution. You have the right to refuse to continue services at anytime. You and your family have the right to confidentiality. Information about your treatment or services with Transformations can be released to you or others only with your written consent. Exceptions to this law apply when the client or family member is in danger of causing injury to self or someone else. In limited circumstances the courts can force a therapist or service provider to release records to the legal system.

**Responsibilities**

As a client or client guardian, you have the responsibility to provide accurate and complete information and to report any changes in the client’s well-being.

You have the responsibility to keep all appointments to the best of your ability and to give 24 hour notice to the provider if you are unable to keep an appointment.

You are responsible to maintain the client's insurance card and to report any lapse in coverage to the service provider.

You are responsible to contribute to the formulation of a treatment plan with its goals and objectives and to follow through with your agreed upon interventions.

TRANSFORMATIONS: HOPE FOR TODAY'S FAMILIES, LLC

NOTICE OF PRIVACY PRACTICES

08/13/2014

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 BEFORE SIGNING.

1. Understanding your health information

When you/your child begins working with Transformations a record of treatment is made. Typically, this record contains you/your child's history, assessment, medical information, diagnoses, treatment, a plan for future treatment, etc. This information often referred to as you/your child's health or medical record, serves as:

\*Basis for planning your/your child's care and treatment

\*Legal document describing the care you/your child received

\*Means by which you or a third party payer can verify that services billed were provided

\*A source of data for health officials charged with improving the health of the nation, or needed services for the area

\*A tool by which future or continual services can be approved

Understanding what is in this record will help you to ensure its accuracy, better understand who, what, when and why others may access you/your child's information and help to make more informed decisions when authorizing disclosure to others.

**YOUR HEALTH INFORMATION RIGHTS**

Although the health record is the physical property of Transformations, the information belongs to you. You have the following rights:

Right to Request a Restriction

You have the right to request a restriction on our use and sharing of you/your child's protected health information. Transformations can deny the request if it is unreasonable or would be detrimental to your/your child's treatment.

Right to a paper copy of this Notice

You have a right to obtain a paper copy of this notice. You may obtain a copy by notifying Transformations office at 502/899-5411 or mailing a request to 4010 Dupont Circle, Suite 582, Louisville, KY 40207.

Right to amend your/your child's health information

You have the right to request the agency to amend the health information we maintain about you/your child if you feel it is incorrect or incomplete for as long as the information is kept by Transformations. To request an amendment, you must submit a request in writing and state the reason that supports your request. The disputed information will remain in the record along with the amended information. Transformation may deny your request if the request is not submitted in writing, does not contain a reason to support the request, the information that is being questioned was not originated by Transformations, it is not part of the information which you are permitted to inspect or copy, or it is currently accurate and complete.

Right to an accounting of disclosures

You have the right to obtain an accounting of the disclosures Transformations made of health information about you/your child. This does not include disclosures made for treatment, payment, or health care operations, made directly to you, made for national security reasons, or made to corrections or law enforcement personnel. Your request must state a time period that must be no longer than (6) six years and may not include dates before April 14, 2003. The first list requested within a (12) twelve month period will be free. For additional lists, you will be charged for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to request alternative means of communication

Transformations’ staff may seek to communicate with you through general common practices such as your cell phone, text messages, email, voice mail, the U.S. Postal service, etc. It is our policy to take reasonable measures to secure electronic communications. You have the right to request communication of your/your child's health information by alternative means or alternative locations. For example, you could request Transformations only contact you at work or by mail. To request communications by alternative or restricted means, you must submit your request in writing. You will not be asked the reason for your request and your request will be accommodated. Your request must indicate how or where you want to be contacted.

Right of access to protected health information

You have the right to request, either verbally or in writing your/your child's health information with certain exceptions. Transformations will respond to you within (30) thirty days (or (60) sixty days if extra time is needed). If your request is denied you have the right to have the request reviewed by a reviewing official who did not participate in the original decision to deny access. In accordance with Kentucky State Law 422.317, Transformations will provide, without charge to the client, a copy of the client's medical record. There will be a charge for any additional copies after that based on cost.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

*Transformations will use your/your child's health information for treatment. We will use and disclose your/your child's protected health information in providing treatment and services. We may disclose your/your child's protected health information to agency and non-agency personnel who may be involved in your/your child's treatment. This will include any one you designate to be apart of the child’s service team including a Targeted Case Manager, Therapist, Community Support Associate, Psychiatrist, or Physician providing care to your child. We may also disclose protected health information to individuals who will be involved in your/your child's treatment after you are no longer associated with Transformations. This will guarantee the continuity of care.*

*Transformations will use and disclose you/your child’s protected health information so that billing and payment for services for the treatment of you /your child can occur. For billing and payment purposes we will disclose information to Medicaid, Medicaid’s billing agent, or an insurance or managed care company, the DMHMRS, or any other designated third party payer. This disclosure for billing will continue after services are ended in order to secure reimbursement for services. Transformations will also disclose your/your child’s health information to a managed care company or peer review organization designated by Medicaid or your third party payer, in order to secure and maintain authorization for treatment. Transformations will use your/your child's health information for regular health care operations. Transformations may use data separated from identifiable information for researcher and program development purposes. These uses and disclosures are necessary to manage the agency and our quality of care.*

**EXAMPLES OF USES AND DISCLOSURES FOR OTHER SPECIFIC PURPOSES**

As required by law we will disclose you/your child's protected health information.

\*Disaster Relief-to an agency organizing disaster relief efforts

\*Public Health Activities-such as: reporting to a public health or government authority for preventing or controlling disease, injury, or reporting child abuse or neglect

\*Food and Drug Administration (FDA)-concerning adverse events or problems with products or medications for tracking purposes to enable product recalls or to comply with other FDA requirements

\*to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition

\*for certain purposes involving workplace illnesses or injuries

\*Reporting victims of abuse, neglect or domestic violence-information will be disclosed as required by law

\*Judicial and Administrative proceedings-information may be disclosed in response to a court or administrative order, subpoena, discovery requests, or other lawful process. Efforts will be made to notify you about the request or to obtain an order or agreement protecting the information

\*Health oversight activities-information may be disclosed to a health oversight agency for activities authorized by law, such as, audits, inspections, investigations, licensure actions or other legal proceedings.

\*Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations

\*to avert a serious threat to health or safety-any disclosure would be made only to someone able to prevent the threat of safety to you/your child, the public or another person

\*research-only under your/your child's specific disclosure

\*Workers Compensation

\*Law Enforcement-as required by law to comply with reporting requirements including, but not limited to: complying with court orders, warrants, subpoenas, summons, identifying or locating a fugitive, missing person or material witness, when information is requested about the victim of a crime if the individual agrees, to report information about a suspicious death, to provide information about criminal conduct occurring at the agency, or information about emergency circumstances about a crime. \*National Security and Intelligence Activities, Protective Services for the President and others.

\*Only data that has been separated from my identifiable information may be used for research and program development purposes, pursuant to 45 CFR 46.101(b.2). Protected health information is may only be used for research only if authorized through written release of information.**YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES**

**OF PROTECTED HEALTH INFORMATION**

Transformations will use and disclose protected health information (other than described in this Notice or required by law) only with your written authorization. You may revoke your authorization to use or disclose protected health information in writing, at any time. If you revoke your authorization, we will no longer use or disclose your/your child's protected health information for the purposed covered by the authorization except where we have already relied on the authorization.

**OUR RESPONSIBILITIES REGARDING YOUR/YOUR CHILD'S**

**PROTECTED HEALTH INFORMATION**

Transformations is required by law to:

\*maintain the privacy of your/your child's health information

\*provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about your child

\*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 alternative means or at alternative locations.

We reserve the right to make changes to this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. Any changes made will affect the protected health information we maintain at that time. We will post a copy of the current Notice at our office site. We will provide a revised copy of the Notice to parents/legal guardians upon request on or after the effective date of revision.

**WE WILL NOT USE OR DISCLOSE YOUR/YOUR CHILD'S PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.**

If you have questions, would like additional information, or feel your rights have been violated, you may contact the Privacy Officer**: Laura Krebs Lewis, 4010 Dupont Circle, Suite 582, Louisville, KY 40207**. **lkrebslewis@transformationsllc.net.**

If you have any other complaints or concerns you may also call the privacy officer and clinical director at **502-899-5411.**

If you are still dissatisfied you may file a complaint by sending a written statement to the above address

Laura Krebs Lewis

4010 Dupont Circle Suite 582

Louisville KY 40207

or to:

Office of Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F

HHH Building

Washington, DC 20201

Transformations will not retaliate against you if you choose to file a privacy complaint or exercise your privacy rights.

**Quality Assurance Program**

Transformations is committed to supporting its providers in learning new and better ways to help you. So your feedback on our services is important to help us know what we need to change. Transformations will be emailing you a few brief questionnaires. Please answer each survey as you receive it. The surveys will be sent through a secure HIPAA compliant website and email system. You may also contact us at any time at office@transformationsllc.net or call me personally at 502-905-9494.

Thank you for choosing Transformations as your service provider.

Sincerely,

Teri Lloyd,LMFT

Clinical Director