**THE P3 PURSUIT, LLC AUTHORIZATION/CONSENT PACKET**

**THE P3 PURSUIT, LLC**

**REFERRAL FOR SERVICES**

**(Please use this form to refer a person to The P3 Pursuit, LLC)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Information** |  | | **Referring Agency Information** |
| **Name:** |  | | **Name of Agency:** |
| **Street Address:** |  | | **Person Making Referral:** |
| **City, State & Zip Code:** |  | | **Telephone:** |
| **Telephone:** |  | | **Date of Referral:** |
| **Date of Birth:** |  | | **Please contact me immediately for more information.** |
| **You may leave a message at above telephone number.** |  | | **Contact me with an appointment time for the person referred.** |
| **Please do not leave message at above telephone number.** |  | | **Contact me if this person does not keep appointment.** |
|  | | | |
| **Services Requested** | | | |
| **Behavioral Health Screening to Determine Need for Further Assessment(s) and/or Treatment (Note: There is no charge for this service.)** | | | |
| **Mental Health Assessment** |  | **Psychiatric (Medication) Assessment** | |
| **Developmental Disability Assessment** |  | **Psychiatric Rehabilitation** | |
| **Alcohol and/or Drug Abuse Assessment** |  | **Treatment for:** | |
| **DUI/DWI (Signup on Mondays at 9:00 a.m. — Date: \_****)** | | | |
|  | | | |
| **Additional Information about the Person Referred** | | | |
| **Specific Problems that Need to be Addressed:** | | | |
| * **Suicide Risk: □YES □NO □N/A** * **Danger to Self or Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Urgent/Critical Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Immediate Threat(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Past Psychiatric Admission(s): □YES □NO □N/A** * **Previous Outpatient Treatment: □YES □NO □N/A** * **Primary Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **The more information you can provide us, the better we will be able to help the person you are referring. Please use this space to provide additional information. If possible, include information about symptoms or behaviors that have prompted the referral, stressors affecting the person’s ability to function, and natural supports such as family, friends, church, etc., that may support treatment. Please attach additional sheets as necessary.** | | | |
| **Assessment summary with treatment recommendations must be received by this office by:** | | | |
|  | | | |
| **Insurance Information** | | | |
| **Medicaid (MCO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  | **Medicaid (#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** | |
| **Private Insurance** |  | **Referring Agency** | |
| **Medicare** |  | **Limited Income: Will need discounted fees** | |
| **Flex Funding Plan** |  | **Other Payer Source:** | |
|  | | | |
| **Under state and federal law, information about mental health treatment and substance abuse treatment is confidential and protected. If you would like to receive a copy of the assessment or want to be kept informed of progress in treatment, please ask the person to sign this Authorization to Release Information and fax it THE P3 PURSUIT, LLC AT 443-898-6199 OR Email at:** [**tbrice@thep3pursuit.com**](mailto:tbrice@thep3pursuit.com) | | | |

**MEDICAL NECESSITY CRITERIA**

**Psychiatric Rehabilitation Program Services (PRP)**

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

**Name of Client Referring Clinician Signature**

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

**Diagnosis Date**

**FACTORS OR CRITERIA JUSTIFYING THE NEED FOR PRP SERVICES**

The client’s mental illness is the cause of serious dysfunction in one or more life domains (home, school, community). Please site examples of dysfunction in one or more life domain.

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

Based on the clinical evaluation and ongoing treatment plan, PRP services are indicated and are expected to reduce the symptoms of the client’s mental illness or the functional behavioral impairment that is a result of the mental illness.

The impairment as a result of the client’s mental illness results in: (Please check all that apply)

* A clear, current threat to the individual’s ability to be maintained in his or her customary setting, or
* An emerging/pending risk to the safety of the individual or others, or
* Other evidences of significant psychological or social impairment such as inappropriate social behavior causing serious problems with peer relationships and/or family members.
* Please site examples of impairments.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The individual, due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.

Either:

* There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the client’s symptoms and functional behavioral impairment resulting from the mental illness and restore him or her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the individual or others.
* Please explain:   
  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***OR***

* For individuals transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care. Therapist will make referral to PRP program. The client will be connected with an Outpatient Mental Health Center or mental health provider.
* Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* The individual’s disorder can be expected to improve through medically necessary rehabilitation or there is clinical evidence that this intensity of rehabilitation is needed to maintain the individual’s level of functioning; and
* The individual is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.

**PRP SERVICE REQUIREMENTS**

* Outpatient mental health services and social supports should be identified and available to the individual outside the program hours and the individual or the individual’s parent/guardian should be capable of seeking them when needed when the individual is not attending the rehabilitation program.
* There is a documented crisis response plan both inside and outside of program hours coordinated with the primary mental health clinician treating the individual that indicates clear responsibility for the mental health clinician and rehabilitation program.

***PLEASE NOTE:***  In order to initiate service you are required to follow the Three Step Referral Process:

1. Confirm the client is interested in Psychiatric Rehabilitation Day Program Services.
2. Complete the Referral Form.
3. Forward the completed Form. Please use the fax number OR email listed

Requirements for the Referral Process: Based on COMAR regulations

1. Clients that have Medical Assistance may start services within a week of receiving the returned referral information.
2. Clients that have only SSDI and Medicare as their primary are considered uninsured for PRP.

PLEASE NOTE: Presently uninsured clients have no guarantee of authorization from Beacon Health and therefore may take longer to be approved for services. A Licensed Mental Health Professional’s signature is REQUIRED on the referral form. In order to establish and maintain eligibility for PRP SERVICES, individuals MUST remain under the care of a psychiatrist and/or therapist while in the program.

**Name of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Health/Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*FOR OFFICE USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Appointment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE P3 PURSUIT, LLC**

**ACKNOWLEDGEMENT FOR INTANKE AND ADMISSI ON**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The following are required for all clients receiving services through The P3 Pursuit, LLC. A copy of this acknowledgement will be kept in the client case record.*

|  |
| --- |
| **ACKNOWLEDGEMENT OF RECEIPT OF CLIENT HANDBOOK** |
| Your signature on this form indicates that you have received a copy of the P3 Pursuit, LLC Client Handbook. The handbook contains policies, rules, regulations and a brief overview of the program. Some of the policies included in the handbook include:   * The Right of Clients to Refuse Treatment Policy * Clients Rights & Responsibilities Policy * Notice of Privacy Practices * Client Grievance Policy * Gift Giving and Appropriate Boundaries Procedures * Program features * Fees and payment options * Involvement in publicity, fund raising and research programs   Your signature further indicates that:   * You understand that the handbook is only meant to answer general questions about the program and specific questions or concerns can be forwarded to the appropriate personnel. * You understand that it is your responsibility to read the contents herein and understand them * A representative of the program has reviewed the handbook with you including the policies listed above and that you understand them |

|  |  |
| --- | --- |
| **ACKNOWLEDGMENT OF RIGHT TO FREE INTERPRETER SERVICES** | |
| * Client does NOT require Free interpreter services * Client requires and requests free interpreter services * Client requires and declines Free Interpreter Services   (complete box to the right) | P3 is required under law to provide sign language interpreters for clients or potential clients with hearing impairments at no cost to the individual. P3 provides foreign language interpreters to Limited English Proficient clients at no cost to the individual. P3 defines an interpreter as, “an individual who is qualified to convert one spoken language into another or, in the case of sign language interpreters, between spoken communication and sign language.”  I understand that P3 is required to provide these services to me for free. My initials to the left indicate that I chose to decline this offer of free interpreter services. |
| **EMPLOYEE USE ONLY (Fill out below if applicable)**  What type of interpreter services or assistance is needed for the client  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

My signature below indicates my understanding of and consent to the above policies.

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

Client Date

(Legal custodian may sign for client under 5 years old after document

Has been read to them and all questions answered)

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

Legal Custodian Date

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

Birth Parent Date

*As a representative of The P3 Pursuit, LLC I have explained the statements contained within this form, and I have ensured that the client and his or her parent(s) or legal custodian named above understand the statements contained in this form to the best of his or her ability*

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

The P3 Pursuit, LLC Representative Date

**THE P3 PURSUIT, LLC CONSENT FOR SERVICES AND TREATMENT**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned client/parent/legal custodian, hereby provide consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive services via The P3 Pursuit LLC. The selects below also indicate my consent for the following:

1. **Counseling**

Agree to participate in group and/or individual counseling and/or rehabilitative services. The goals are developed collaboratively with the clinician and are based on the client’s needs, concerns and recommendations of the referring agency.

* Consent
* Do NOT Consent

1. **Benefits or Risks**

Understand that counseling and rehabilitative services is a process that can help me/the client make life changes to a more positive and productive lifestyle. Counseling is most effective when clients are motivated to embrace new options and follow through with new actions during the week between sessions. If counseling does not result in the change I/the client hoped, I will discuss this with the clinician. The primary risk of counseling is that the process may involve discussion problems or life events that may evoke unpleasant and challenging emotions.

* Consent
* Do NOT Consent

1. **Confidentiality/Privacy of Information**

Understand that in most situations, information discussed in a group setting session is kept confidential, there are some exceptions described below that include:

* 1. If I/the client threatens to harm or death to self or another person, P3 is legally, ethically and morally required to act to protect the safety of the threatened person. Actions should include: informing the intended victim; arranging for hospitalization, notifying family or support system; alerting law enforcement
  2. If abuse or neglect of child or a person who is elderly or with a disability is known or suspected, P3 is required by law to report these concerns to state protective services.
  3. If P3 receives a legally binding court order for its records, or for a deposition or court testimony the agency is required to comply
* Consent
* Do NOT Consent

1. **Participation in Research**

Understand that The P3 Pursuit, may participate in research studies. I/client understand that if provided the opportunity to participate in a study, participation is completely voluntary and the decision of whether to participate in research arises, I/Client will be provided the option to agree to or decline participation after receiving:

* An explanation of the nature and purpose of the research
* A clear description of possible risks or discomfort
* A guarantee of confidentiality
* Consent
* Do NOT Consent

1. **Participation in Video and Media Photographs/Publicity**

* Consent
* Do NOT Consent

**Authorization to Obtain, Use and Disclose Personal Health Information**

I understand that The P3 Pursuit has an obligation to keep my personal information, identifying information, and records confidential. I also understand that I may choose to allow The P3 Pursuit, LLC to release some of my personal information to certain individuals or agencies.

I hereby voluntarily authorize the written or oral disclosure of information from my record as identified below.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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|  |  |
| --- | --- |
| **Information is to be released to:** | **Information is provided by** |
| **THE P3 PURSUIT** | Agency/Individual |
| Address | Name/Position |
| City, State, Zip Code | Address |
| Phone/Fax | City, State, Zip Code |
| Email | Phone/Fax |
|  |  |

***Records are requested for the purpose of:***

* Attorney
* Further medical care
* Personal Use
* Court Actions
* Insurance
* School
* Disability
* Monitoring/Oversight Activities
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Requested Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Present or past date) (Present or future date)

Dates of Verbal Communication from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Present or past date) (Present or future date)

**INFORMATION TO BE RELEASED:**

|  |  |  |
| --- | --- | --- |
| **INFORMATION TO BE RELEASED** | | |
| ***Assessment/Social History*** | ***Medical*** | ***Education*** |
| * Discharge Plan * Incident Reports Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Neurological * Progress Notes * Psychiatric Hospitalization Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Psychological Testing Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Psychological Evaluation Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Social/Family History * Treatment Plans * Treatment Recommendations | * Birth Records * Developmental History * Drug & Alcohol Records * Hospitalization Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Immunization Records * Lab Reports * Medical History * Medications * Mothers Prenatal Records * Physical Exams * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Academic School Records * ARD Report * Attendance Records * Complete Behavior Checklist * Disciplinary Actions * Evaluation Report (Most Recent) * IEP Current * Teachers Observations * Two-Way Verbal Communications * Two-Way Written Communications * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

HIV, Behavioral health (psychiatric), and Drug and Alcohol Information contained in the parts of the record(s) indicated above will be released through this consent unless otherwise indicated below

DO NOT RELEASE: \_\_\_\_HIV \_\_\_\_Behavioral Health \_\_\_\_Drug and Alcohol

I understand that I may withdraw my authorization at any time by submitting a Request for Revocation of Authorization to Obtain, Use and Disclose Protected Health Information to P3 Pursuit, except:

1. To the extent that the action has been taken in reliance on this authorization
2. If the authorization was obtained as a condition of obtaining insurance coverage; or
3. If a policy of insurance or other law provides the insurer with the right to contest a claim under the policy
4. If the authorization has not been revoked, it will terminate **12 months** from the date of my signature, unless I have specified a different expiration date or expiration event

I understand that information disclosed by this Authorization, expect for alcohol and drug abuse, as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [CFR PART 164] or the Privacy Act of 1974 [5 USC 552a]

I understand that P3 Pursuit, LLC will not condition treatment or eligibility for care on my providing authorization, expect of such care is research-related or provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that I have the right to object to the release of PHI and to refuse to sign this authorization. I understand that P3 PURSUIT, LLC provision of services is not contingent on the decision concerning release of PHI or payment for services rendered, and that the PHI will be released pursuant to all applicable state and federal laws, rules and regulations.

*I have read this form, it has been explained to me, and I understand its content. This authorization remains in effect until\_\_\_\_\_\_\_\_\_\_\_\_\_\_ no longer than 12 months. This authorization is given for a one-time release of information or, if no date is indicated, authorization shall expire* ***90 days*** *from the date this form is signed.*

Client (14 years of age or older)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Custodian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Authorized Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P3 PURSUIT, LLC Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this authorization is not signed in the presence of a P3 PURSUIT, LLC employee the signature must be notarized

Sworn to and subscribed for me this\_\_\_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_.

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

(My commission expires NOTARY PUBLIC

My signature as Notary Public verifies the Signer’s identification have been validated

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place stamp here**

**VERBAL AUTHORIZATION- NOT APPLICABLE TO HIV RELATED INFORMATION**

**I witness that the client (or legal custodian/personal representative, when applicable) is unable to provide a signature, but understood the nature of this release of information and freely gave his/her verbal authorization (THE P3 PURSUIT, LLC representative signature above and additional witness required).**

Additional Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is to be released for the purposes stated above and may not be able to be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning the individual from a federal agency under false pretenses shall be guilty of a misdemeanor.

**THE P3 PURSUIT, LLC**

**CONSENT FOR INFORMATION**

Complete all sections below, date and sign

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_, hereby voluntarily authorize disclosure of information from my record

(Name of Client) (DOB)

|  |  |
| --- | --- |
| **Information is to be released to:** | **Information is provided by** |
| **P3 PURSUIT, LLC** | Agency/Individual |
| Address | Name/Position |
| City, State, Zip Code | Address |
| Phone/Fax | City, State, Zip Code |
| Email | Phone/Fax |

The purpose or need for this disclosure is: (check all that apply)

□ Further Medical Care □Attorney □School □Research □Insurance □ Disability

□For Marketing/Advertising Purposes □ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information to be disclosed from my record:

* Entire Record
* Only information related to (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Only the period of events from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (specify e.g., billing)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-client privilege)*

If you would like any of the following sensitive information disclosed: (check appropriate boxes)

* Alcohol/Drug Abuse Treatment/Referral
* Sexually Transmitted Diseases
* HIV/AIDS-Related Treatment
* Mental Health *(Other than Psychotherapy Notes)*

I understand that I may revoke this authorization in writing submitted at any time except to the extent that THE P3 PURSUIT. Has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the client’s counselor/behavioral assistant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, stating my intent to revoke this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. The expiration event can be a future event (e.g., discharging from P3).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Enter expiration date or event. I understand that P3 Pursuit, LLC will not condition eligibility for services on my providing authorization except if such services are provided solely for the purpose of creating Personal Health Information for disclosure to a third party.

Parent/Legal Custodian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Authorized Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P3 PURSUIT, LLC Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE P3 PURSUIT, LLC**

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_the undersigned, hereby give my permission to undergo any assessments, treatment or other procedure deemed reasonable and necessary by The P3 Pursuit, LLC staff for my diagnosis, treatment, follow-up or referral at P3 This may include, but is not limited to emergency care, psychosocial assessment, psychiatric assessment, counseling, medication administration and any other behavioral health services provided as part of my treatment.

My consent shall also include a personal history, which will assist the staff in developing a treatment plan and in providing treatment. If appropriate, I further give my consent to undergo random urine screening to determine if alcohol or drugs have been used by me. I give my consent for individual, couple, family and/or group therapy as deemed necessary by The P3 Pursuit, LLC staff.

I give my consent for the staff of P3 including, but not limited to my psychiatrist, clinicians, interns or staff, to share information within the agency about my treatment.

I hereby acknowledge that mental health and substance abuse treatment may have limitations, which the client can discuss any concerns with clinician.

I hereby authorize payment directly to The P3 Pursuit, LLC of benefits due to me for reason of treatments, procedures and medicine afforded to me and further assign any major benefits due, all of which payment shall not exceed the regular services of P3 or the staff thereof for the treatment afforded to me. I agree that a photocopy of this authorization is as valid as the original.

**MEDICARE CLIENTS ONLY**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or any subsequent Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment of such claim.

**CLIENTS UNDER THE AGE OF 18** (Minor children 16 & over may consent for psychotherapy, however may not consent for psychiatric services without parental consent until the age of 18).

I attest that I am the custodial parent. (Initial) \_\_\_\_\_\_\_❒ yes ❒ no ❒ n/a

There are no legal/custody issues preventing my child from receiving services ❒ yes ❒ no ❒ n/a

I have provided a copy of custody agreement to P3 Pursuit, LLC \_\_\_\_\_ (Please Initial)

**CONSENT FOR TREATMENT:**

I hereby ❒ GIVE ❒ DO NOT GIVE Consent for treatment

**CONSENT FOR FOLLOW-UP:**

Upon termination of services, The P3 Pursuit may want to contact you regarding your status and for you to answer some questions concerning satisfaction of the services you received. The purpose of this information is to ensure the continuity of care and to provide P3 PURSUIT, LLC with pertinent statistical information. You may revoke permission for follow-up at any time by giving a written notice or by refusing to participate in any follow-up questionnaires. Follow-up will be the same for all clients served regardless of referral status.

**CONSENT FOR FOLLOW-UP**: I hereby ❒ GIVE ❒ DO NOT GIVE THE P3 PURSUIT, LLC permission to contact me by telephone, letter or email for follow-up information and to answer questions concerning my satisfaction with services and my current status.

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

Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE P3 PURSUIT, LLC FINANCIAL POLICY DISCLOSURE AND CLIENT PAYMENT AGREEMENT**

Financial Management and Obligations If you do not have insurance that pays for your treatment at The P3 Pursuit, LLC you will be assessed a fee based on Maryland’s sliding fee scale. It is in your best interest to pay your fee weekly. If you are unable to pay or your money situation changes you must inform your counselor and/or the fee administrator immediately. Falling behind in your fee payment may result in loss of take-home, paying daily before medication, or discharge from the program

1. **AUTHORIZATION TO RELEASE INFORMATION**: I hereby authorize The P3 Pursuit, LLC to release medical information pertaining to my medical treatment as requested by Third Parties in order to secure payment of services rendered P3
2. **AUTHORIZATION TO PAY INSURANCE BENEFITS:** I hereby authorize any insurance or third-party benefits, related to this mental health treatment, to be paid directly to The P3 Pursuit, LLC
3. **CHANGES IN COVERAGE:** I will notify The P3 Pursuit. immediately if I have any changes or lapse in insurance coverage.
4. **PAYMENT GUARANTEE:** In consideration of the acceptance of the above-named client by The P3 Pursuit, LLC and for the services rendered to said client, the undersigned hereby guarantees payment of any and all charges made by P3.
5. If placed on a sliding fee scale, I will provide accurate and updated financial information no less than every 6 months. I am required to pay for any services provided to me by P3 based on the written financial agreement.
6. **NON-PAYMENT POLICY** In an effort to adopt a policy that will be applied equitably to all agency clients, the following guidelines will be followed:
7. All clients are expected to pay their fees/copays at the time of service.
8. Clients who have an outstanding balance of $100.00 or more will be notified that they must pay at least $10.00 of this balance in addition to their co-pay/fee at each appointment.
9. Non-payment may result in suspension of services, to include all future appointments until the client presents with payment.
10. Appointments will be scheduled after receipt of payment due.
11. Should 60 days lapse without payment, the client will be notified of pending discharge, 30 days from the date of letter unless payment due is received. If the undersigned fail(s) to make any payments due hereunder, P3 may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise(s) to pay all cost of collection, including, but not limited to, court costs, attorney’s fees and any other collection fees which are incurred by or on behalf of the agency in enforcing payment after default. 6.

**MEDICARE ASSIGNMENT:**

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its’ intermediary or carriers any information needed for this or a related Medicare claim. I understand I am responsible for any deductible or co-insurance.

If more than one person signs this Disclosure/ Agreement, their liability shall be joint and several.

By signing this document there is the understanding that all medical, diagnostic, and treatment information will only be released to the appropriate insurance carriers as designated by the signer.

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The P3 Pursuit Discharge and Transition Plan**

* The P3 Pursuit, LLC is dedicated to quality care and service. It is important that you understand our policy for transitioning to a lower level of service when goals are met and/or treatment is no longer necessary.
* You may be discharged from services if you have not participated in treatment for a period of 30 days or you have missed three consecutive appointments. A discharge warning letter will be mailed to your home prior to termination from the program.
* A decision to terminate may be made by your treatment team if all your identified treatment goals have been met and symptoms have stabilized.
* If you are unable to attend treatment services for a temporary period due to hospitalization, traveling or other temporary reason your services will remain open as long as information is communicated with your direct service provider.
* Program Services may be discontinued at the request of the consumer or their legal guardian.
* Discharge and transition will be a collaborative effort between all members of your treatment team. A set transition plan will be set to facilitate transfer to new level of care.
* Initial treatment goal: establish rapport with direct service staff and participate in assessment and development of individual rehabilitation goals and objectives. Services will be provided both in the home, community and in the office. Client formal Individual Rehabilitation Plan (IRP) will be developed within 30 days of start of services.

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

Signature of Client or Client representative Date

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

Therapist/Rehabilitation Specialist/Counselor Date

**THE P3 PURSUIT, LLC**

**CLIENTS RIGHTS POLICY**

**CLIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*As a client of The P3 Pursuit, you have the right to:*

1. Receive appropriate humane treatment, which minimizes restriction of your personal liberty only to the extent necessary for your treatment needs, and applicable legal requirements.
2. Be protected from harm and to be free from mental, physical and sexual abuse at the facility. All allegations of client abuse by staff members must be reported to the local law enforcement agency or to the program director that must report them to the local law enforcement agency.

* A rehabilitation plan.
* Participate, in a manner appropriate to your condition, in the development and periodic review of your treatment plan.
* Receive treatment as stated in your individualized treatment plan.

1. Be told in appropriate terms and language of:
   1. The contents and objectives of treatment or rehabilitation;
   2. The nature and significant possible negative effects of treatment or rehabilitation;
   3. The name, title and role of staff members who are directly involved in your treatment, and when appropriate, the names of other treatments, services, or providers of mental health services.
2. Access your treatment records and the right, with written permission, for your attorney to have access to your records. In the event your treatment provider believes that it would be harmful to you to read your record, you have the right to a written summary of those sections of the record your treatment provider believes might be harmful.
3. Refuse medication.
4. Refuse to participate in physically intrusive research.

* Prior to admission, to an explanation in terms and language that you can understand of admission and discharge policies.
* Prior to admission, to an explanation of your rights in terms and language that you can understand, and to have a list of your rights posted in a prominent place in the facility.
* Prior to admission, to an explanation in terms and language that you can understand, of the charges and fees that you will be required to pay.
* An aftercare plan.
* File a grievance if you are not satisfied with the treatment/services that youreceive.

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**Program Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**The P3 Pursuit, LLC Cancellation/No Show Policy**

We understand that unanticipated events happen occasionally in everyone’s life. However, when you do not call to cancel or keep an appointment, you may be preventing another client from getting the services that they need. In the agencies plan to be effective and fair to all clients, the following policies outline regulations regarding cancelling appointments and no show policies.

**Please read and initial**

1. **\_\_\_\_\_\_: 24-hour advance notice is required** when cancelling/rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment.
2. **\_\_\_\_\_\_: No-show/No Call/Missed Appt:** Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a “no-show" and recorded in your file. After the third rescheduled appt, we will be unable to put you on the schedule. ***Please keep in mind that it may be a few weeks before an appointment becomes available to see the assigned staff***
3. **\_\_\_\_\_\_: Late Arrivals:** We provide you with a grace period of 5 minutes. If you arrive late for your appointment, it may be rescheduled on a case by case basis. Out of respect and consideration to the doctor and therapist, **please** plan accordingly and be on time.
4. \_\_\_\_\_\_: **Appointment Confirmation:** We do provide courtesy calls but ultimately, it is your responsibility to remember your scheduled appointments. If we are unable to reach you to confirm your appointment, we have the right to cancel it and put another client in that time slot.
5. \_\_\_\_\_: **Rehabilitation Services:** If three consecutive "no-shows/missed appt" are documented in your file, an intent to discharge letter will be sent out. If we do not hear back from you in a stated time period, you will be discharged from the program.

**I have read and understand this policy.**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**THE P3 PURSUIT, LLC**

**FINANCIAL POLICY DISCLOSURE AND CLIENT PAYMENT AGREEMENT**

1. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize The P3 Pursuit to release medical information pertaining to my medical treatment as requested by Third Parties in order to secure payment of services rendered by The P3 Pursuit, LLC.

2. **AUTHORIZATION TO PAY INSURANCE BENEFITS:** I hereby authorize any insurance or third-party benefits, related to this mental health treatment, to be paid directly to The P3 Pursuit, LLC.

3. **CHANGES IN COVERAGE:** I will notify The P3 Pursuit, LLC immediately if I have any changes or lapse in insurance coverage.

4. **PAYMENT GUARANTEE:** In consideration of the acceptance of the above-named client by The P3 Pursuit, LLC and for the services rendered to said client, the undersigned hereby guarantees payment of any and all charges made by The P3 PURSUIT, LLC. If placed on a sliding fee scale, I will provide accurate and updated financial information no less than every 6 months. I am required to pay for any services provided to me by The P3 PURSUIT, LLC based on the written financial agreement.

5. **NON-PAYMENT POLICY** In an effort to adopt a policy that will be applied equitably to all agency clients, the following guidelines will be followed:

1. All clients are expected to pay their fees/copays at the time of service.
2. Clients who have an outstanding balance of $100.00 or more will be notified that they must pay at least $10.00 of this balance in addition to their co-pay/fee at each appointment.
3. Non-payment may result in suspension of services, to include all future appointments until the client presents with payment.
4. Appointments will be scheduled after receipt of payment due.
5. Should 60 days lapse without payment, the client will be notified of pending discharge, 30 days from the date of letter unless payment due is received. If the undersigned fail(s) to make any payments due hereunder, The P3 Pursuit, LLC may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise(s) to pay all cost of collection, including, but not limited to, court costs, attorney’s fees and any other collection fees which are incurred by or on behalf of the agency in enforcing payment after default.

**MEDICARE ASSIGNMENT:** I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its’ intermediary or carriers any information needed for this or a related Medicare claim. I understand I am responsible for any deductible or co-insurance.

If more than one person signs this Disclosure/ Agreement, their liability shall be joint and several. By signing this document there is the understanding that all medical, diagnostic, and treatment information will only be released to the appropriate insurance carriers as designated by the signer.

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**THE P3 PURSUIT, LLC**

**Advanced Directive:**

I have received, read and understand the above Introduction to the Advanced Directive for Mental Health Treatment and decided as follows:

* I currently have an Advanced Directive for Mental Health Services. (see attached copy)
* I currently do not have an Advanced Directive for Mental Health Services and request assistance with an appointed staff to make one at this time. (See attached copy)
* currently do not have an Advanced Directive for Mental Health Services and do not wish to have one at this time.

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*ACKNOWLEDGMENT OF CLIENT HANDBOOK\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

By my signature below, I hereby acknowledge that I have received an orientation to P3 PURSUIT, LLC treatment program in terms that I understand and a copy of the organization’s clients Handbook that contains additional information about the organization’s rules and regulations. I also acknowledge that I have received a copy of “About Treatment” and agree to read it completely. I acknowledge that the ***program*** staff have discussed the facts about treatment within the agency.

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been given the opportunity to ask questions and have received a copy of the P3 Pursuit, LLC Client Handbook.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Social Security Number Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Client’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Provider’s Signature Date

**THE P3 PURSUIT, LLC**

**CONSENT FOR PRESCRIPTION MEDICATION**

**Consent from a parent, legal guardian or client is sought prior to the administration of any prescription medication.**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, self, parent/legal custodian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client Name)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** consent to the administration of prescription as directed by the treating physician and in

*(Client DOB)* accordance with The P3 Pursuit, LLC policy and state regulations. The P3 Pursuit, LLC has provided all information as required by the *Medication* *Administration and Control* policy. I understand that I may revoke or modify this consent at any time bygiving written notice to The P3 Pursuit, LLC. Any changes to this consent will take effect after the receipt of the writtennotice by The P3 Pursuit, LLC.

I hereby request and authorize The P3 Pursuit, LLC to monitor the self-administration of medication prescribed by a licensed physician, psychiatrist or nurse practitioner. In doing so, I relieve the agency and its employees of any responsibility that may result from the client's refusal of his or her said medication.

Authorization expires one year from date of signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Client Date

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

Parent Date

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

Legal Custodian Date

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

Other Date

This signed form will be placed in the client’s case record.

As a representative of The P3 PURSUIT, LLC, I have explained the statements contained in this form and I have ensured that the client and his or her parent or legal custodian named above understand the statements contained in this form to the best of each of his or her ability.

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

The P3 PURSUIT, LLC Representative Date

**THE P3 PURSUIT, LLC**

**INFORMED CONSENT FOR NAXALONE TREATMENT:**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is Naloxone?**

Naloxone (Narcan) is an antidote to opioid overdose. It is an opioid antagonist that is used to reverse the effects of opioids. Naloxone works by blocking opiate receptor sites. It is not effective in treating overdoses of benzodiazepines (such as Valium, Xanax, or Klonopin), barbiturates (Seconal or Fiorinal), clonidine, Elavil, GHB, or ketamine. It also is not effective in treating overdoses of stimulants such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

Before giving your consent, be sure you understand both the pros and cons of the naloxone rescue kit. If you have any questions, we will be happy to discuss them with you. Do not sign your initials at each section or your name at the end of this form until you have read and understood each section. Do not sign until the pharmacist has answered your questions and can witness your signature. This information is confidential. Contents: The naloxone rescue kit I will receive contains: Needle-free syringes of naloxone rescue medication Nasal adaptors Patient handout with instructions how to administer naloxone Written material containing information on overdose prevention, recognizing overdose, responding, and aftercare information including information on obtaining refills

**Overdose Antidote:**

* I understand that I will be given naloxone because I am at risk to stop breathing and of death due to an opioid overdose.
* I understand and can recognize the signs and symptoms of an overdose.
* I understand that naloxone is a drug that reverses an opioid overdose.
* I understand that naloxone can reverse an overdose, but does not treat abuse or addiction.
* I understand how to use and administer the naloxone to both myself and to someone else.
* I understand naloxone may cause withdrawal symptoms, including nausea, vomiting, sweating, fast heart rate, increased blood pressure, & shakiness.
* I understand that naloxone may cause withdrawal symptoms within minutes after administration, which can last for an hour or more.
* understand that most opioids remain in the body longer than naloxone, and that I could overdose again after the naloxone wears off.
* I understand that naloxone will reverse an overdose from opioids including morphine, codeine, fentanyl, oxycodone, hydrocodone, OxyContin®, Percocet®, Vicodin®, other prescription pain medications, heroin and methadone.
* I have been shown/understand how to put the naloxone together to use in case of emergency.
* I understand naloxone does not prevent deaths caused by other drugs such as benzodiazepines, cocaine, methamphetamines or alcohol.

**Additional Information:**

* I understand I must return to the pharmacy to request a refill or to replace an expired medication.
* I have been counseled on how to avoid an overdose and what to do if an overdose occurs.
* I understand my pharmacist is available to provide information on substance abuse/treatment & that I can ask questions at any time.
* I understand when to call 911 & the Poison Center (1-800-222-1222), which is free & anonymous. The pharmacy can be contacted at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Sharing Information:**

* I understand it is strongly encouraged to share this treatment information with my family & friends.
* I understand it is strongly encouraged to teach family & friends how to respond to an overdose.
* I understand that my provider will be notified that I am obtaining naloxone. I understand that my signature below indicates that I have received a copy of the Notice of Privacy Practices, addressed any questions/concerns and have read and understood the information on starting the naloxone therapy.

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Client/Patient Printed Name Client/Patient Signature Date