the TRANSITION HOUSE

Client Name: (Please Print) _____

Date: _____

TYPE OF INTAKE

Thank you for choosing The Transition House Inc. to provide you with services, please read over the following documents carefully and if you have any questions please inform staff and we will clarify or answer any questions that you may have.

What is the reason for you coming here today?

__Mental Health Evaluation
__Substance Use Evaluation
__Psychiatric Evaluation
__Psychological Evaluation
__Couples counseling
__Family Counseling
__Group Counseling
__Psychoeducational Classes
__Intensive Outpatient Program

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HEALTH SCREENING – OUTPATIENT

Information supplied by: ☐ INDIVIDUAL ☐ OTHER (specify name and relationship):	**DATE**:
NAME (Last, First MI)	**BIRTHDATE:**
RECENT IMMUNIZATION? (Tetanus, Flu, Pneumonia)	
DO YOU HAVE ANY ALLERGIES? NO ☐ YES (If YES, to what & explain reaction below): ☐	
FEMALES ONLY: Date of last Menstrual Period Menopause Post Menopause	

DO YOU HAVE ANY OF THE FOLLOWING?Please circle No or Yes

Unsteady Walks or falls	NO	YES	Lung Problems	NO	YES	Mental Illness	NO	YES
Ringing in the ears	NO	YES	Swallowing Problems	NO	YES	Hepatitis/Jaundice	NO	YES
Fractures/Dislocations	NO	YES	Nausea / Vomiting	NO	YES	Mononucleosis	NO	YES
Arthritis/Back/Neck Problems	NO	YES	Weight gain/loss last 6 months	NO	YES	Tuberculosis	NO	YES
Heart Problems/Chest Pains	NO	YES	Diabetes	NO	YES	Sexually Transmitted Disease	NO	YES
Heart Murmur	NO	YES	Thyroid Problems	NO	YES	Cancer	NO	YES
Ankle/Leg Swelling	NO	YES	Gastrointestinal Problems	NO	YES	Cold/Sore Throat/Sinusitis	NO	YES
Blood Pressure Problems (H/L)	NO	YES	Ulcer / Rectal Bleeding	NO	YES	Bleeding Disorders / Anemia	NO	YES
Peripheral Vascular Disease	NO	YES	Kidney / Urinary Problems	NO	YES	HIV / AIDS	NO	YES
Difficulty Breathing / Asthma	NO	YES	Stroke/Seizure/Severe Headache	NO	YES	Other: _		
Chronic Bronchitis/Emphysema	NO	YES	Dizziness/Blackouts/Fainting	NO	YES			

EXPLAIN ANY YES ANSWER:

LIST ALL SIGNIFICANT MEDICAL PROBLEMS No Medical problems

Date Defined	Medical Problem	Duration	Under Physician Care	Physician	Meds Prescribed

NAME OF PRIMARY CARE PHYSICIAN: **DATE OF LAST PHYSICAL:**

May we contact your doctor to request further information about your medical condition? YES NO

Do you need a referral for a Primary Care Physician? YES NO

If you have not seen a Primary Care physician in the last 12 months we strongly suggest you make an appointment, if you do not have a PCP your Primary Counselor will assist you with a local PCP referral.

I am aware that maintaining my health is important, especially when taking medications. As such I am aware of the necessity to schedule yearly physical and eye exams. It is also important to get routine lab work (CBC, Chemistry Profile, and Urinalysis); EEG (electrocardiogram), and Thyroid Profile whenever it is recommended. If I am on medication I will be asked to get lab tests done to test my medication level, for example, Lithium Level. I understand it is my responsibility to follow through with the above recommendations.

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RECEIPT OF PRIVACY PRACTICE

The Transition House has the right to change the way information is shared and to make changes for all protected health information it keeps. Changed forms will be given to you and displayed where you can see them.

I have received a copy and understand my rights as it applies to the Private Health Information that The Transition House keeps about the services given to me.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not disclose to a person outside this facility that a client is attending the program or disclose any information identifying a client as a drug abuser, unless one of the following apply:

1. The client consents in writing.

2. The disclosure is permitted by a court order.

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violations of Federal law and regulations are a crime and suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal law and regulations do not protect any information relating to a crime committed either at the facility or against any person who works for the facility or about any threat to commit such a crime.

Federal law and regulations do not protect any information relating to suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities.

Reference 42 U.S.C.290dd.3 and 42 U.S.C.290ee.3 FOR Federal law 42 CFR Part 2 for Federal regulations

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

CONSENT FOR TREATMENT

Before we begin working with you we are required to have your consent for interview. Please read the following statement. I certify that I am participating in an interview with the Outpatient program for services. I give my consent for the initial interview to begin.

I voluntarily agree to participate in The Transition House Treatment Outpatient Program. I understand that my sincere and successful participation in this program will enhance by well-being, as well as promote stability at home, school, and in the community.

Participation in this program is not a guarantee against prosecution or ultimate incarceration. I hereby agree to participate in the Program. The conditions of the program and my responsibilities have been reviewed and explained to me by a Transition House Representative. I have been informed of the services provided by the agency and of my rights pertaining to confidentiality. I understand that this document serves as a formal agreement to accept and participate in services via The Transition House.

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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URINALYSIS TESTING

Urine samples may be requested for the purpose of evaluating treatment needs and/or monitoring treatment progress. Consistent positive urinalysis results may lead to termination of service. Test results are confidential except when consent for release of information has been completed or as legally required. I consent to provide urine samples for testing whenever requested. I understand that the testing may be used to evaluate my need for treatment and/or my progress in treatment.

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

CONSENT FOR INTER-AGENCY COMMUNICATION

I authorize The Transition House to receive or communicate pertinent information related to the client and services being provided during participation in the program. This may include, but is not limited to the exchange of written, including via secure encrypted e-mail, or verbal information with contracted agencies. I understand that this information will be protected and that confidentiality will be safeguarded.

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

PRIVACY PRACTICE

The Transition House has the right to change the way information is shared and to make changes for all protected health information it keeps. Changed forms will be given to you and displayed where you can see them.

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CONFIDENTIALITY AGREEMENT

The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not disclose to a person outside this facility that a client is attending the program or disclose any information identifying a client as a drug abuser, unless one of the following apply:

1. The client consents in writing.

2. The disclosure is permitted by a court order.

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Violations of Federal law and regulations are a crime and suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal law and regulations do not protect any information relating to a crime committed either at the facility or against any person who works for the facility or about any threat to commit such a crime. Federal law and regulations do not protect any information relating to suspected child abuse or neglect from being reported under State Law to appropriate

State or local authorities. Reference 42 U.S.C.290dd.3 and 42 U.S.C.290ee.3 FOR Federal law 42 CFR Part 2 for Federal regulations

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

GRIEVANCE PROCEDURE

Anytime you think that an action taken by a Transition House Representative is unjust or you believed that you are being treated unfairly, or you are dissatisfied with services, you can make a complaint. This complaint is called a GRIEVANCE. To file a grievance, the procedure is as follow:

First, if possible, try to work out the issue with The Transition House Representative and/or their Supervisor. If this is not successful, write out your grievance on a Grievance Form posted by the Grievance Procedure and give to either the Supervisor of your program or a Transition House Representative with whom you feel comfortable. Within fifteen (15) working days, the Supervisor will discuss the grievance with you and try to resolve the matter. The Supervisor will write you as to what, if any action will be taken on your grievance. If you are not satisfied with the Supervisor's decision, you have the right to appeal, in writing, to the Chief Executive Officer or you have the right to request a formal hearing with The Transition House, Inc., the Chief Operating Office, and the CEO. The administration of The Transition House has fifteen (15) working days to review, investigate your grievance, and notify you of their findings and any actions that may be warranted. A final formal hearing would be scheduled at your convenience and a resolution to your satisfaction will be sought as quickly as possible.

You always have the right to take your grievance further to the Indiana Family and Social Services Administration 1-800-901-1133. All grievances will be reviewed by the Quality Management Committee.

NOTE: NO ACTION WILL BE TAKEN AGAINST YOU FOR FILING A GRIEVANCE

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

CLIENT'S RIGHT

The following are your rights as a client who has elected to receive services from The Transition House Inc. agency:

1. To receive services without regard to race, sex, age, creed, or religion.

2. Your personal dignity is recognized and respected in providing care and treatment.

3. To receive services within the least restrictive environment possible.

4. To not be denied services based solely on race, gender, ethnicity, age, sexual orientation, HIV status, prior service departures, disability, language, socioeconomic status, religion, or relapse.

5. I understand that I have the right to request a copy of my file by notifying The Transition House program in writing and providing proper identification.

6. To receive treatment from an adequate number of competent, qualified and experienced professional Clinical staff to supervise and implement the treatment plan.

7. You have the right to request the opinion of a consultant at your expense or to request a review of your treatment plan, as provided in specific procedures of The Transition House.

8. You may request a referral through the Clinical Director.

9. You have the right to know the risks, side effects, and benefits of all medication and treatment procedures used and informed available alternate treatment procedures.

10. You have the right, to the extent permitted by law, to refuse the specific medications or treatment procedures.

11. You have the right to know as appropriate, the cost of services rendered, the source of our reimbursement, and any limitations placed on duration of services.

12. You shall be informed of any proposed change in the professional staff responsible for you or for any transfer of you within or outside the organization.

13. You have the right to initiate a complaint or grievance procedure through the Clinical Director.

14. Your records are protected under state and federal confidentiality laws, which prohibit unauthorized disclosures of information and to have an understanding of these laws.

15. To be assured freedom from neglect, abuse, exploitation or any form of corporal punishment and should you feel that you are being mistreated, contact the Indiana Family and Social Services Administration at 317-618-0293.

16. To be assured that any search and seizure is carried out in a manner consistent with program standards and only to ensure the safety, well-being, and security of all clients and staff.

ABUSE REPORTING POLICY

Indiana state law requires oral reports shall be made to the Department of Child Services, which hosts a toll-free child abuse hotline (1-800-800-5556) or the local law enforcement agency.
If an individual is required to make a report in his or her capacity as a member of the staff of a medical or other public or private institution or as a member of the staff of a hospital licensed under 31-33-5-2.5, IC 16-21-12, school, facility, or agency, the individual must immediately notify the individual in charge of the hospital, institution, school, facility, or agency or a designated agent

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

OUTPATIENT ORIENTATION

Welcome to the Outpatient Center. You are now a voluntary participant in our treatment program. Our vision for you is to provide counseling services to the behavioral health population in a safe and therapeutic environment, which includes addiction education and exploration of client strengths to regain a healthy and productive lifestyle. Our responsibility is to help you by educating you about your illness of addiction and co-existing conditions and to help you explore ways to stay free of illicit drug use and get your life back on track.

We may make recommendations for other services in order to help create full stability of mind, body and soul. We also will provide individualized and group counseling services to enhance this process when deemed necessary.

How the program works:

From admission to treatment, you are evaluated by our counseling staff. This evaluation process includes interviews with you and drug screening as needed to assess clinical needs. Once the initial screening and assessment process is complete, you will be provided a follow-up appointment with the counseling staff. All further appointment needs will be assessed and scheduled at the follow-up visit. Counseling sessions may be required for the first four weeks of treatment pending outcome of initial screening/assessment process.

Program Rules:

The following rules and regulations have been established by the program to ensure that a safe and therapeutic environment is maintained for the benefit of everyone. The examples listed below are not meant to be all-inclusive, but are a representation of the intent.

- Acts of physical violence or threats of violence toward staff or clients will not be tolerated. Physical violence will result in police intervention.
- No abusive, vulgar, or profane language will be permitted while on the premises.
- No overt sexual conduct will be permitted
- Possession and/or use of any type of weapon on clinic premises will be cause for immediate termination and police intervention as deemed necessary. 5) Use of possessions/dealing of any illicit drugs or substance is prohibited on clinic premises and could result in immediate termination from treatment and police intervention.
- Theft of any kind within the program will result in immediate termination and police intervention.
- You must inform the counselor of any prescription drug you may be taking in order to avoid drug interaction/contraindications.
- Loitering or panhandling is not permitted on premises.
- You must provide a urine sample upon request from counselor and will be charged for all urine screenings as listed in the payment policy, if not covered by your insurance.

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Payment Policy:

The Transition Outpatient Center operates on Health insurance benefits, Federal contracts and patient fees for services. Fees are due at the time services are rendered and must be paid in money order, check, or credit card, if applicable.

NO CASH WILL BE ACCEPTED

A $45.00 fee applies to all returned checks. No refunds will be provided for services already rendered.

If any scheduled appointments are missed without at minimum 24-hour notice, the client is responsible for a $45 cancellation fee.

Additional Fees: (subject to change)

Substance Abuse Evaluation: $147.00
Mental Health Evaluation: $165.00
Individual Counseling: $74.00
Group Counseling: $35.00
Couples Counseling $110.00
Psychiatric Evaluation $350.00
Psychological Evaluation (depending on type) $210.00 - $650.00
Court representation: $40 per hour
Court Probation Reports: $35.00
Urine Drug Screen: $25.00

Refund Policy

A refund will be issued if it is an insurance requesting an overpayment refund. Before the request is filed a dispute/appeal must be processed to determine if a refund is genuinely necessary.

A refund will be issued in the case where an individual is a self-paying client and has prepaid for services. If the individual cancels within the appropriate time frame that amount will be refunded to the individual.

I am acknowledging that I understand the program rules and payment policies, I am acknowledging that I have received a copy of each of these from an employee at TTHI.

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

GUARANTEE OF PAYMENT

I the undersigned, hereby agree to guarantee the payment of the bills for services rendered by The Transition House, Inc. Also, I agree to sign as guarantor or as client that in consideration of the services to be rendered to me, to be hereby jointly and individually obligated to pay the account of T.T.H.I. in accordance with the regular rates and terms of T.T.H.I. I understand that if the account is referred for collection by an attorney or collection agency, I will be responsible to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any account(s) not paid when due.

In consideration of the treatment and services rendered or to be rendered, by The Transition House, Inc. to the extent permitted by law, I hereby irrevocably assign, transfer and set over to T.T.H.I. (II) all of my rights, title and interests to medical reimbursement, including but not limited to, (III) the right to designate a beneficiary, add a dependent, eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreements otherwise payable to me for whose services rendered by T.T.H.I. during the dependency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery of said policy (s) of insurance, but shall not be construed to be an obligation of T.T.H.I. to pursue any such right of recovery. I hereby authorize the insurance company's) or third party payers) to pay directly to T.T.H.I. all benefits due for services rendered.

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

CONSENT FOR RELEASE

I, the undersigned authorize T.T.H.I. to release all client information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which I am being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Transition House, Inc. to any insurance company, and/or third party payers, or representatives providing coverage for this admission, or to any T.T.H.I. representative. I acknowledge that this information may not be released to any other person or entity unless I authorized the TTHI Representative to do so.

I, the undersigned acknowledge that such disclosure 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. Furthermore, I authorize T.T.H.I to release information for the purpose of obtaining preauthorization for treatment and concurrent review and to release that information to medical review agencies, and/or third party payers, providing coverage or having responsibilities for the admission.

I, the undersigned have been informed by the TTHI Representative the confidentiality of alcohol and drug abuse client records are protected by federal law regulations. Therefore, I understand that T.T.H.I. may not disclose information to anyone outside of T.T.H.I., which would identify any clients as an alcohol or drug abuser unless the client 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.

I, the undersigned have been informed by the TTHI Representative that the 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 officials.

I, the undersigned hereby authorize free exchange of medical record information, including but not limited to the release of client information indicated above, between T.T.H.I and the attending therapist, his/her group practice association and/or other health care agencies, facilities and/or professionals which may provide services to clients during this admission. This includes the authorization to discuss the client's specific information indicated above with a TTHI Representative.

I, the undersigned acknowledge his/her right to request and receive a copy of this authorization for release of information and may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. Furthermore, the undersigned acknowledges that this authorization shall be valid until all third party payers liable are evolved for this admission of service.

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____

the TRANSITION HOUSE

ADVANCE DIRECTIVES

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

The undersigned acknowledges the following: I have been given written materials about my right to accept or refuse treatment: I have been informed of my rights to formulate Advance Directives. I understand that I am not required to have an Advance Directive in order to receive treatment at this facility I understand that the terms of any Advanced Directives that I have executed will be followed by the facility and the employees of T.T.H.I to the full extent of the law. PLEASE CHECK ALL THAT APPLY:

__Yes, I have a medical advanced directive

__No, I do not have a medical advanced directive

__Yes, I have a psychiatric advanced directive

__No, I do not have a psychiatric advanced directive

Client signature: _____ Date: _____

Guardian Signature: _____ Date: _____