Welcome to Rebound Mental Health…

I am glad that you are here and look forward to meeting you.

This *Welcome Packet* contains the forms you will need to complete, sign, and bring to your first appointment. It is **very important** that you complete the *Welcome Packet* **prior** to your appointment.

The first 1-4 sessions will focus on:

- Paperwork!
- Review the policies and guidelines we follow at Rebound Mental Health.
- Answer any questions or concerns you may have about paperwork and/or the therapeutic process.
- Learn about you and how I can best serve you.
- Help you know what to expect from me as your therapist.

I understand the paperwork portion can seem long and tedious, but it helps us get to know one another and how we can work together.

When we meet, I will ask you questions about things which may make you uncomfortable. You are always welcome to decline answering a question.

What's important is that we have open communication and make sure that we'll be a good fit. If you think that's not the case after our first couple of meetings, just let me know. No hard feelings. And if I feel that I may not be the best person to meet your needs, I will let you know who I think could be a better fit.

I understand that you probably won't remember everything we go over, so please make a copy of this *Welcome Packet*. If you ever have any questions, ask me. If I make any updates or changes, I'll let you know right away.

Finally, "Like" our Facebook page so you can receive notifications about mental health information and resources.

https://www.facebook.com/pg/reboundmhtulsa/posts/?ref=page_internal

Sincerely,

Carrie Short LCSW, BCD
Marti Robey-Fox LPC
Regina Underwood LPC, RPT
Jenny Kauffman LCSW
Katie Pyle LMSW

REBOUND MENTAL HEALTH
6202 South Lewis Avenue, Suite A, Tulsa, OK 74136
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www.reboundmh.org

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Patient Registration Form

PATIENT INFORMATION

Patient's Last Name	First	MI	☐ single ☐ married ☐ divorced ☐ widowed	Sex

Mailing Address	City	State	Zip

Phone #1	☐ work ☐ home ☐ mobile ☐ other	Phone #2	☐ work ☐ home ☐ mobile ☐ other
( )		( )	

DOB (mm/dd/yy)	Social Security #	E-mail Address	Sign here for email appointment reminders
			X

Employer	Employer's Address	Employer Phone
		( )

Patient's Primary Care Physician	Physician Phone
( )	( )

PARENT/GUARANTOR INFORMATION

Parent/Guarantor	DOB (mm/dd/yy)	Home Phone #	Mobile Phone #
		( )	( )

Address	City	State	Zip

INSURANCE / EAP INFORMATION

Last Name of Insured (Policy Holder)	First Name of Insured	Social Security #	DOB (mm/dd/yy)

Insured's Address	City	State	Zip

Insured's Place of Employment	Phone Number	Insured's Email Address
	( )	

Name of Insurance or EAP	Customer Serv. #	Member ID #	Group #	Copay/Co-Ins.

FOR CHILDREN UNDER THE AGE OF 18

If legal custody is shared, has permission by other parent been granted for treatment?	☐ Yes	☐ No
To whom may we release information?		

REFERRAL INFORMATION

Who referred you for services?	

EMERGENCY CONTACT (other than patient or guarantor)

Contact Name	Relationship to Patient	Home Phone #	Mobile Phone #
		( )	( )

The above information is accurate and correct to the best of my knowledge. By signing, I consent to treatment for the above-named patient.

Patient/Guardian Signature:		Date:	

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Credit Card Information

I agree to keep my correct and updated credit card information on file to be used for missed appointments, records, letters, and/or outstanding balances. This information is for internal use only and will not be distributed to third parties.

(Circle one) MasterCard or Visa

Credit Card Number _____ - _____ - _____ - _____

Expiration date _____/_____ CVC Code _____ Zip code _____

Name as it Appears on Card _____

Signature _____

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PRESENTING PROBLEMS AND CONCERNS

ICD Code: clinician use only_____

Client Name:_____ **Date:**_____

Describe the problem that brought you here today:_____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Hygiene
- ☐ Legal matters
- ☐ Sexual activity
- ☐ Self esteem
- ☐ Work/School
- ☐ Finances
- ☐ Health
- ☐ Relationships
- ☐ Housing
- ☐ Recreational activities

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself?
If yes, please describe:_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else?
If yes, please describe:_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else?
If yes, please describe:_____

☐ Yes ☐ No Have you gambled in the past 6 months? If yes, let us know the following
- ☐ Yes ☐ No Have you ever felt the need to bet more and more money?
- ☐ Yes ☐ No Have you ever had to lie to people important to you about how much you gambled?

Therapist Notes:_____

_____

_____

_____

_____

Initials:

Client Name:_____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together
☐ Parents Temporarily separated together
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times_____
☐ Father remarried: Number of times_____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Therapist Notes:_____

Initials:

PREVIOUS MENTAL HEALTH TREATMENT

		Type of Treatment	When?	Provider	Reason for Treatment
☐ Yes	☐ No	Outpatient Counseling			
☐ Yes	☐ No	Inpatient Counseling			
☐ Yes	☐ No	Medication (mental health)			
☐ Yes	☐ No	Drug/Alcohol Treatment			
☐ Yes	☐ No	Self-Help/Support Groups			

Therapist Notes:_____

Initials:

Client Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

Therapist Notes: _____

Initials:

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Abortion	☐ Sleep disorder	☐ Other:

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

Therapist Notes: _____

Initials:

Client Name:_____

INTERPERSONAL / SOCIAL / CULTURAL INFORMATION

Please describe your social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center

To which cultural or ethnic group do you belong?_____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe:_____

_____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very Much

☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents?_____

_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____

_____

Therapist Notes:_____

Initials:

MISCELLANEOUS INFORMATION

Employment

Employer:_____ Position:_____

Length of time in this position:_____ Job Duties:_____

Stress level of this position: ☐ Low ☐ Medium ☐ High

Other jobs you have held:_____

Education

☐ Yes ☐ No Are you currently attending school?

☐ High School Graduate Year_____ ☐ GED Year_____

☐ Associate's Degree Year_____ Major area of study_____

☐ Undergraduate Degree Year_____ Major area of study_____

☐ Graduate Degree Year_____ Major area of study_____

Military Service

☐ Yes ☐ No Have you been/are you currently in the military? (if no, skip remainder of this section)

Branch_____Date of Discharge_____Type of Discharge_____Rank_____

☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain_____

_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain

_____

Therapist Notes:_____

Initials:

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Adverse Childhood Experience (ACE) Questionnaire

Client Name_____Date_____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often…..
   Swear at you, insult you, put you down, or humiliate you?
   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes enter 1_____

2. Did a parent or other adult in the household often…..
   Push, grab, slap, or throw something at you?
   Ever hit you so hard that you had marks or were injured?

   Yes No If yes enter 1_____

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   Try to or actually have oral, anal, or vaginal sex with you?

   Yes No If yes enter 1_____

4. Did you often feel that….
   No one in your family loved you or thought you were important or special?
   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes enter 1_____

5. Did you often feel that….
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes No If yes enter 1_____

6. Were your parents ever separated or divorced?

   Yes No If yes enter 1_____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes No If yes enter 1_____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes enter 1_____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

   Yes No If yes enter 1_____

10. Did a household member go to prison?

    Yes No If yes enter 1_____

Total_____

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Authorization to Release/Obtain Confidential Information

I understand that my records contain information about my therapy sessions and my mental health. I understand that all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose. Therapists will limit client's and/or guardian's access to records when there is compelling evidence that access would cause harm to the client. A photocopy of this authorization will be considered as valid as the original.

I, _____ _____ _____
Client Name | Date of Birth | Social Security Number

AUTHORIZE:_____
Rebound Mental Health
6202 South Lewis Avenue, Ste. A.
Tulsa, OK 74136
Phone/Fax: 918.949.4515/918.949.4523

TO RELEASE OR OBTAIN INFORMATION FROM:
_____
_____
_____
Attn:_____

Description of information to be disclosed or shared:

- ☐ **ALL OF THE INFORMATION BELOW** **If this box is checked, do not check additional boxes**
- ☐ Treatment Planning
- ☐ Psychological Assessments
- ☐ Discharge Summary
- ☐ Psychiatric Testing / Evaluations
- ☐ Health and Medication History
- ☐ Eligibility/Determination of Insurance or benefits
- ☐ Other: _____
- ☐ Other: _____
- ☐ Insurance / HMO Transactions
- ☐ Sooner Care Determination Forms
- ☐ Drug and Alcohol Information
- ☐ Psychological Testing / Evaluations
- ☐ Psychosocial History
- ☐ Progress Notes

Purpose of Requesting this Information: **Share information relevant to treatment**

How to Release Information (check all that apply): _____verbal _____written _____fax _____all

THIS RELEASE EXPIRES ON:_____; however, I understand I have the right to revoke this release at any time.

I have been informed and understand this authorization to release records and information, the nature of listed content I am willing to release, and the implications of this release. This request is voluntary.

Rebound Mental Health, LLC, is hereby released of all illegal liability that may arise from the release of information requested.

_____ _____
Client Signature (14 and older) | Date

_____ _____
Signature of Parent, Guardian, or Auth. Representative | Relationship to Client | Date

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I, _____ _____ _____
Client Name | Date of Birth | Social Security Number

AUTHORIZE: _____
Rebound Mental Health
6202 South Lewis Avenue, Ste. A.
Tulsa, OK 74136
Phone/Fax: 918.949.4515/918.949.4523

RELEASE TO OR OBTAIN INFORMATION FROM:
Rebound Mental Health
6202 South Lewis Avenue, Ste. A.
Tulsa, OK 74136
Attn: Treatment Team

Description of information to be disclosed or shared:

- ☐ **ALL OF THE INFORMATION BELOW** **If this box is checked, do not check additional boxes**
- ☐ Treatment Planning
- ☐ Psychological Assessments
- ☐ Discharge Summary
- ☐ Psychiatric Testing / Evaluations
- ☐ Health and Medication History
- ☐ Eligibility/Determination of Insurance or benefits
- ☐ Other: _____
- ☐ Other: _____
- ☐ Insurance / HMO Transactions
- ☐ Sooner Care Determination Forms
- ☐ Drug and Alcohol Information
- ☐ Psychological Testing / Evaluations
- ☐ Psychosocial History
- ☐ Progress Notes

Purpose of Requesting this Information: **Share information relevant to treatment**

How to Release Information (check all that apply): _____verbal _____written _____fax _____all

THIS RELEASE EXPIRES ON:_____; however, I understand I have the right to revoke this release at any time.

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Rebound Mental Health, LLC, is hereby released of all illegal liability that may arise from the release of information requested.

_____ _____
Client Signature (14 and older) | Date

_____ _____
Signature of Parent, Guardian, or Auth. Representative | Relationship to Client | Date

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ACKNOWLEDGMENT
Policy, Procedures, Disclosures and Consents

Attendance Policy

Please Initial that you have read_____

When completing counseling services, continuity is vital to success. Frequent cancellations or failing to schedule appointments can lead to delays between therapy sessions that may impede progress. As a mental health service provider, I try to assist in finding suitable times for s to meet for sessions. Our success is a joint effort; therefore, your cooperation in keeping appointments is critical to your success. I would like to outline for you the attendance policy for
Rebound Mental Health, LLC, 6202 S. Lewis Ave., Ste. A., Tulsa, OK 74136.

1. To schedule appointment, please call (918) 949-4515
2. We require a minimum of 24-hour notice for changes or cancellations of appointments. If you do not cancel with a minimum of 24-hour notice, the patient is responsible for the fees accrued.
3. Please contact the clinic/therapist as soon as you are aware you need to cancel. (This is also within the minimum of 24-hour notice)
4. If you are late for an appointment, the appointment will still end at the scheduled time.
5. If you cancel or do not show up for two consecutive appointments, all future appointments will be taken off of the books. In this case, call the clinic to schedule a time suitable for you. RMH will reserve the right to close your file. Two no-shows may result in end of duty of care.
6. Office hours are Monday – Thursday 9:00 a.m. to 5:00 p.m. by appointment only.

Contact Information:

Office #: (918) 949-4515
Fax #: (918) 949-4523

cshort@reboundmh.org
mfox@reboundmh.org
runderwood@reboundmh.org
jkauffman@reboundmh.org
kpyle@reboundmh.org
chall@reboundmh.org
aramsey@reboundmh.org

Email Reminder Consent

Please Initial that you have read_____

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your service provider's name. We will not encrypt the messages. Health care information sent by regular email could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. ***If you understand the risk*** and would like to receive an appointment reminder by email, please confirm you accept responsibility for these possible risks and will not hold Rebound Mental Health responsible for any event that occurs after we send the message. ☐ Yes, I'd like an email reminder_____

Signature

No Show and Late Cancellation Fee Policy

Please Initial that you have read_____

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, RMH reserves the right to charge a fee of $50.00 for all missed appointments ("no-shows") and appointments not cancelled with a 24-hour advance notice ("late cancellation").

This fee will be charged to the card we have on file or will be billed to you. This fee is not covered by insurance and **must be paid prior to your next appointment**. Multiple "No Shows" or "Late Cancellations" of appointments may result in termination from our practice.

How do I cancel my appointment to avoid a fee?
You can cancel your appointment by:

- Calling Rebound Mental Health at 918-949-4515 or
- Cancelling in person by coming into our office.

No Recording and Penalty Policy

Please Initial that you have read_____

I/we agree that I/we will NOT audio or video record ANY portion of my/our therapy, consultation, parenting coordinator meeting or evaluation sessions with the Rebound Mental Health Clinician without their expressed written consent.

This policy applies to any other party I have included in my/our sessions or asked to provide information to any of the Rebound Mental Health Clinicians on my/our behalf. I/we understand that there is a $150,000.00 penalty that I/we agree to pay to my Rebound Mental Health Clinician for breaching this policy.

After Hours Instructions

Please Initial that you have read_____

1. If you have an emergency, crisis situation, feel out of control, have thoughts of suicide, harming yourself, or hurting others, you will need to contact any of the following:

    - Your local emergency response system 911
    - Local police department
    - COPES - Community Outreach Psychiatric Emergency Services: (918) 744-4800
    - The 24-Hour State Mental Health Hotline: 1-800-522-9054.
    - National Suicide Hotline: 1-800-273-8255

2. Proceed to your nearest emergency room

3. Contact your Clinician's Office: (918) 949-4515

Financial Policy

Please Initial that you have read_____

Below are the terms of agreement regarding payment for sessions at Rebound Mental Health, LLC.

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45 minutes direct with the counselor or professional.
2. If, I the patient fail to appear for an appointment or without 24-hour notice of cancellation, cancellation fees will be charged to the card on file, and I will be responsible for payment.
3. I understand that if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.
4. Services including phone calls, emails, record reviews and professional consults at times other that the scheduled therapy session will be the patient's responsibility and will not be filed with insurance. These services will be billed per quarter of an hour.
5. I authorize my health insurance to provide payment of benefits to Rebound Mental Health LLC.
6. I understand records of my treatment may be shared with my insurance company when necessary to process claims.
7. I understand I am responsible for payment if my insurance company declines payment.
8. Under the circumstances that Rebound Mental Health does not accept your health insurance policy, Rebound Mental Health will supply a receipt of payment for services. You can submit this receipt to your insurance company for reimbursement.
9. Payment must be made by check, cash and/or credit. Your fee or co-pay is due at the time services are provided. The patient is responsible for all fees. This includes any fees denied by insurance providers. Fees must be paid within 30 days after the dated the claim is denied.
10. Returned checks will result in an additional service fee of $25.00
11. Rebound Mental Health reserves the right to utilize a collection agency to obtain unpaid balances.

Fees For Services

Please Initial that you have read_____

We Accept Most Major Credit Cards

Insurance Fees

Therapy Sessions:

Intake		$160.00
Session		$135.00

** Prompt Payment Discount of 20% available for self-pay clients.

Prompt Payment Discount Self-Pay	Intake	$130.00
Prompt Payment Discount Self-Pay	Session	$110.00

Other Fees:

Late Cancellation Fees and No Shows	$50.00
Telephone Consults:	
15-30 mins.	$25.00
30 mins.	$50.00
Correspondence:	
Reports (Schools, employers, professionals)	$50.00

Court Ordered Services:

Reconciliation Counseling, Parent Coordinator, Supervised Visits, Court Ordered Therapy, Therapeutic Supervised Visits

We Only Accept Cash for Court Ordered Services

Intakes:

Reconciliation Therapy	$130.00
Therapeutic Supervised & Supervised Visits	$100.00 TSV / $75.00 SV
Parent Coordinator	$150.00
Guardian ad Litem	$150.00

Sessions:

Reconciliation Therapy	$120.00 per session
Supervised Visits	$ 40.00 per hour
Therapeutic Visits	$ 75.00 per hour
Parent Coordinator	$120.00 per session

In cases where RMH is court ordered to provide services, client will be required to submit payment in advance of services rendered. A retainer is required to cancel scheduled sessions to attend court.
Retainers vary per provider. Court fees will be in addition to retainer.

Court retainer	Half day	$400.00 / $800.00
	Full day	$800.00 / $1200.00
Retainer for Parent Coordinator and Guardian ad Litem		$1000.00

COURT RETAINER MUST BE RECEIVED BEFORE COURT DATE

Court Fees:

Travel/Wait time	$ 75.00 per hour
Consultation/Testimony	$150.00 per hour
Review of Case File	$ 75.00 per hour
Consultation with Attorneys	$150.00 per hour

Rebound reserves the right to change fees at any time.

STATEMENT OF PROFESSIONAL DISCLOSURE

Please Initial that you have read_____

☐ N/A – LCSW (Disclosure not required by State of Oklahoma)

Please check the appropriate license: ☒ LPC **Licensed Professional Counselor**

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation / techniques, experience, fees and credentials. I am licensed to practice by the State Board of Behavioral Health Licensure.

The licensing website is www.ok.gov/behavioralhealth.com where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving you name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe., Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth.com

My Name and Licensee Number is: ☐ **Regina Underwood, LPC - 5521**

☐ **Marti Robey-Fox, LPC - 5399**

REBOUND MENTAL HEALTH
6202 South Lewis Avenue, Suite A, Tulsa, OK 74136
Office: 918.949.4515 Fax: 918.949.4523
www.reboundmh.org

Carrie Short LCSW, BCD
Marti Robey-Fox LPC
Regina Underwood LPC, RPT
Jenny Kauffman LCSW
Katie Pyle LMSW

Consent for Treatment

This consent form is authorized by Section 1-3-102 of Title 10A of the Oklahoma Statutes (effective November 1, 2011).

1. Name of Client: _____
2. Client's Date of Birth: _____
3. I have authority to consent for treatment as stated below (check the appropriate space).
   - ☐ Self (Adult over 18 years of age)
   - ☐ I am a parent of this child.
   - ☐ I am the court appointed guardian of the child. A certified copy of the order appointing me as guardian of the child is attached.
   - ☐ The child has been placed in the custody of the Department of Human Services, and I am a representative of the Department of Human Services authorized to consent to routine and ordinary care.
   - ☐ The Department of Human Services has authorized me, as a person into whose care the named child has been entrusted, to consent to routine and ordinary medical care and treatment. A copy of the document authorizing me to such care is attached.
   - ☐ The Department f Human Services has authorized _____ a facility, to whose care the named child has been entrusted, to consent to routine and ordinary medical care and treatment. I am a person authorized to consent on behalf of said facility.
   - ☐ The court has placed the child in my custody and has determined my authority to consent to routine and ordinary medical care. A copy of the court order granting me this authority is attached.
   - ☐ The court has placed the child in the custody of _____, an institution or agency other than the Department of Human Services and has determined the authority of said institution or agency to consent to routine and ordinary medical care. A copy of the court order granting said institution or agency the authority to consent to routine and ordinary medical care is attached.

I declare under penalty of perjury under the laws of the State of Oklahoma that the statements above are true.

I have read, or had read to me, and understand the following information about my rights:

a) All persons receiving services from REBOUND MENTAL HEALTH, LLC, shall retain all rights, benefits and privileges guaranteed by the laws and constitution of the State of Oklahoma and the United States of America, except those specifically lost through due process of law. [O.S. 43A, Section 1-103(b)]
b) All persons shall have the rights guaranteed by the Department of Mental Health and Substance Abuse Services Client Rights, unless an exception is specifically authorized by those standards or an order of a court of competent jurisdiction. [O.A.C. 450:18]
c) I have been given a summary or full copy of my rights as a client and fully understand their content.

I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered. I also hereby give my permission for follow-up services to include outcome studies by REBOUND MENTAL HEALTH, LLC. I understand that my refusal of follow-up will not restrict my rights to treatment.

_____

Client Signature (14 or older) Date

_____

Parent/Guardian Signature/Representing Authority (required if client is under age 18) Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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Consent for Use and Disclosure of Health Information

I, _____, understand that as part of my health care, Rebound Mental Health, LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent
- The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Rebound Mental Health, LLC, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.596 of the Code of Federal Regulations.

I further understand that Rebound Mental Health, LLC, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.529 of the Code of Federal Regulations. Should Rebound Mental Health, LLC, change their notice, they will provide me with a revised notice.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ☐ **ACCEPT** ☐ **DECLINE** the terms of this consent.

_____ _____
Client Signature (14 and older) Date

_____ _____
Parent/Guardian Signature/Representing Authority (required if client is under age 18) Date

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TeleMental Health Informed Consent

I, _____, (name of client) hereby consent to participate in TeleMental health with my clinician at Rebound Mental Health as part of my psychotherapy. I understand that TeleMental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.
I understand the following with respect to TeleMental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risk and consequences associated with TeleMental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to TeleMental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that TeleMental health services are not appropriate and a higher level of care is required.
6) I understand that during a TeleMental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:_____
and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____
Client Signature (14 and older) Date

_____ _____
Parent/Guardian Signature/Representing Authority (required if client is under age 18) Date

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Statement of Client's Rights (Client Copy)

ALL PERSONS RECEIVING SERVICES SHALL RETAIN ALL RIGHTS, BENEFITS, AND PRIVLEGES GUARANTEED BY THE LAWS AND CONSTITITUION OF THE STATE OF OKLAHOMA AND THE UNITED STATES OF AMERICA, EXCEPT THOSE SPECIFICALLY LOST THROUGH DUE PROCESS OF LAW.

Clients shall have the following rights, unless an exemption is specifically authorized by the ODMHSAS Standards and Criteria or by an order of a court of competent jurisdiction.

1. All clients have a right to be treated with respect and dignity. This shall be construed to protect and promote human dignity and respect for individual dignity.

2. Each client has the right to receive services in a safe, sanitary, and humane living environment.

3. Each client has the right to receive services in a humane psychological environment, which protects them from harm, abuse, and neglect.

4. Each client has the right to receive services in an environment, which provides privacy, promotes personal dignity, and provides opportunity for the client to improve his or her functioning.

5. Each client has the right to receive services without regard to his or her race, religion, sex, ethnic origin, age, degree of disability, handicapping condition, legal status, and/or ability to pay for services provided.

6. No client shall ever be neglected, or sexually, physically, verbally, or otherwise abused

7. Each client has the right to be provided with prompt, competent, appropriate treatment services and an individualized treatment plan.
   a) The client shall be afforded the opportunity to participate in his or her treatment planning, and may a condition or probation, parole, or court order which would subject the client to possible sanctions by the court).
   b) The client's right to consent, or refuse to consent, may be abridged for those clients adjudged incapacitated by a court of competent jurisdiction, and in emergency situations defined by law.
   c) When the client permits, the client's family and/or significant other(s) shall be involved in the treatment and treatment planning.

8. The records of each client shall be treated in a confidential manner.

9. The client has a right to know that his or her records may be subject to review by funding sources and accrediting bodies to verify and evaluate services.

10. Each client has the right to refuse to participate in any research project or medical experiment without informed consent of the client, as defined by law. A refusal to participate shall not adversely affect the services available to the client.

11. A client may voluntarily participate in work therapy and shall be paid just compensation for such work.

12. Each client has the right to request the opinion of an outside medical or psychiatric consultant, at the expense of the client, and/or the right to an internal facility consultation, at no cost to the client.

13. Each client has the right to assert grievances with respect to any alleged infringement of these stated rights of clients, or any other subsequently statutorily granted rights.

14. No client shall ever be retaliated against, or subjected to any adverse conditions or treatment services solely or partially because of having asserted his or her rights as fore stated in this section.

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Notice Of Privacy Policy (Client Copy)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, American Psychological Association Code of Ethics, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257, or the Office of Civil Rights US Department of Health and Human Services, Independence Avenue SW, Rm: 509F, HHS Building, Washington, D.C. 20201 or by calling the OCR Hotline – Voice: 1-800-368-1019.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 2013.

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Acknowledgement Checklist

Please INITIAL next to each statement

Adult Intake Packet:

_____I have completed the

Patient Registration

_____I have completed the

Credit Card Information

_____I have completed the

Presenting Problems and Concerns

_____I have completed the

ACE Questionnaire

_____I have completed the

Authorization to Release/Obtain Confidential Information

_____I have read, initialed, and signed the

Acknowledgment Of: Policy, Procedures, Disclosures and Consents

_____I have received a copy of the

Statement of Client's Rights

_____I have received a copy of the

HIPAA Notice of Privacy Policy Disclosure

By my signature below, I testify that I have had the opportunity to read the Acknowledgments listed above and address all questions and concerns with my therapist, which have been answered fully to my satisfaction.

Patient Name (print) _____

Patient Signature (if over 18 years) _____

Guarantor for Payment (print) _____

Relationship to Patient (circle one) Self Parent/Guardian Other:_____

Guarantor Signature _____Date _____