New Client / Returning Client Intake Appointment Instructions

The following forms can be printed out at home and brought in at the time of your appointment. All forms **MUST** be completed in **BLACK INK** only. Please read carefully so that you can better understand the admission paperwork. You can complete the Medical History and Physical Health Screening prior to your appointment; however please do not complete any of the actual signature sections on any forms.
All Signatures must be witnessed by our Intake Staff.

What to bring to your Intake Appointment

Picture ID

Insurance Card

Proof of Income (if no insurance)
Proof of Income must be supplied for patient & spouse (if working) and/or parents if patient is younger than 18. If proof of income is not brought in at time of Intake, you will be charged full fee for services, until documentation is made available.

Proof of Income that will be accepted:

- recent check stub (past 30 days)
- copy of bank statement showing direct deposits of income
- letter from employer
- W2 wages form
- Most recent tax return
- Notarized letter of support

Copy of Referral Paperwork
If you have been referred through Probation, Northeast Florida Safety Council, Court, Attorney, or another Medical Provider please bring a copy of the referral to your appointment. This helps to ensure that you receive the proper services you have been referred for and/or ordered to attend.

Previous Treatment History
If you have received previous Mental Health or Substance Abuse treatment through another provider, please bring with you the following:

Name of Previous Provider and/or Practice Name
Phone Number
Address

This information will help ensure that we are able to send for any required previous treatment history documentation.

ALL FORMS MUST BE COMPLETED IN BLACK INK ONLY

OPEN ACCESS SCREENING QUESTIONAIRE

Date of Walk-In: ____________________ Returning Client CID# ___________

Client Name: ____________________________________ DOB: ________________ Age: _____

Parent/Guardian Name (if client is a child): ____

Client SSN #: ___________________________________

Mailing Address: _______________________________________ City: ____________________

State: ______________ Zip: ______________

Home Phone: ________________ Cell Phone: ________________ Wk Phone: ______________

Email Address: ____

Does client currently have Florida Medicaid? NO YES

If Yes, What plan? _________________________ ID# ___________________________

Have you recently applied for Medicaid or Food Stamps? NO YES

Does client currently have any Insurance? (Medicare, Private Insurance) NO YES

Insurance Company: _______________________________ ID#: ___________________________
Type of Policy (PPO, HMO, Open Access): __________________ Group #: ________________
Who is the Policy Holder?: ______________________________ DOB: ___________________
Policy Holder SSN #:____________________________
Policy Holder Employer Name: ____

Please provide Insurance Card so that we may keep a copy on file

Who are you referred by?

	Case Worker/Probation/Referral Name & Phone
Department of Children & Families	____________________________________
Family Support Services	____________________________________
Northeast Florida Safety Council	____________________________________
Salvation Army Probation	____________________________________
Department of Corrections	____________________________________
Teen Court	____________________________________
Department of Juvenile Justice	____________________________________
Victims Advocate	____________________________________
Nassau County School Board	____________________________________
State Attorney Office	____________________________________
Other: __________________________	____________________________________

If you do not currently have Medicare or Private Insurance, please answer the following questions:

Monthly Employment Income (Self) $:________________ (Spouse) $: _________________
Social Security Income (Self) $:________________ (Spouse) $: _________________
How many children are you in your home? ____________

If Unemployed, we need a notarized letter that states you are unemployed and who is providing your monthly support (rent, food, utilities, etc…)

Services Requested / Referred for: ____
Reason for today's visit? ____

Rev.10/29/10

SUTTON PLACE BEHAVIORAL HEALTH, INC.

INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I consent and authorize the treatment and therapy that I / my child will receive as a client at Sutton Place Behavioral Health, Inc. I understand that my / my child's therapy may include such techniques as individual, group, family, and marital therapy. I also understand that medication may be prescribed by the Staff Psychiatrist/ARNP, who may change these medications as required for my / my child's benefit. I also understand that my / my child's case may be discussed and/or reviewed by the multi-disciplinary treatment team. All facilities of the Sutton Place Behavioral Health, Inc. are made available to clients without discrimination in regard to age, culture, gender, race, color, religion, spiritual beliefs, national origin, language, socioeconomic status, handicap, or sexual orientation/identity.

All information is confidential, with the following exceptions as mandated by Federal Law: 1. Counselor must report statement indicating threats of harm to yourself or others; and 2. Reports of abuse to children or elderly persons.

RULES, POLICIES & CLIENT BILL OF RIGHTS

As a client of Sutton Place Behavioral Health, Inc., you are guaranteed certain basic rights and responsibilities. It is important that you know and understand them.

RULES

- Sutton Place Behavioral Health, Inc. prohibits clients from participating in physical violence, overt sexual behavior, and possession, use, or sale of alcohol and/or drugs (licit or illicit-excluding use of drugs in accordance with a legal prescription) at all program sites and during all program activities.
- If you have a communicable disease, you must seek treatment from your physician to be enrolled in our programs. Sutton Place Behavioral Health, Inc. has the right to disclose any pertinent information necessary to the Department of Health regarding any possible exposure to any communicable diseases, as required by Chapter 381 and 384 Florida Statutes, known as "Report of Communicable Diseases to Department."

POLICIES

In order to serve you, it is necessary that:

- A mutual agreement must be made between you and your therapist/treatment team as to your goals.
- All scheduled appointments must be met. It is your responsibility to reschedule appointments, whenever this becomes necessary. You will be charged $25.00 for appointments that are not cancelled with a 24-hour notice. Missing three appointments that are not cancelled accordingly may result in your termination from our program.
- Fees are based on the type of services provided. If you have private insurance and Sutton Place Behavioral Health, Inc.'s staff are approved providers, we will file claims with your insurance company. All applicable insurance co-pays, co-insurances, and deductibles must be paid at time of checking-in for services. Clients who are not covered by insurance will be assessed on a Sliding Fee Scale to determine your financial responsibility for services.

CLIENT BILL OF RIGHTS

As a client of Sutton Place Behavioral Health, Inc., you are guaranteed certain basic rights:

- To receive treatment and other program services in quantity and quality that is unaffected by age, race, color, religion, spiritual beliefs, culture, language, national origin, gender, handicap, sexual orientation/identity, and/or socioeconomic status.
- To meet with your therapist and other staff members with reasonable notice to discuss your treatment plan and rate of progress.
- To develop the treatment plan conjointly with your therapist/treatment team and to express your choice in the make up of your treatment team.
- To know the rules and policies that you will be expected to observe.
- To refuse treatment or to leave the program. To be advised of problems, medical, legal or otherwise, that may result from such action.
- Should you observe or experience abuse here at Sutton Place Behavioral Health, Inc., please inform any staff member immediately. You may also report it to the Florida Department of Children & Families at 1-800-96-ABUSE, Florida Local Advocacy Council (904) 723-2133, Human Rights Advocacy Committee 1-800-342-0825, or the Advocacy Center for Persons with Disabilities 1-800-342-0823..
- If you have any complaints or suggestions and your counselor/therapist is unable to respond, you may address concerns to the CEO or Team Leader at Sutton Place Behavioral Health, Inc.

CONFIDENTIALITY OF CLIENT RECORDS

The confidentiality of client records maintained by this program is protected by Federal Law and Regulations. Generally, the staff at Sutton Place Behavioral Health, Inc. may not say to a person outside the program that a client attends the program or disclose any information identifying a client as a client UNLESS:

- The client consents in writing;
- The disclosure is allowed by a written court order;
- The disclosure is made to medical personnel in a medical audit or program evaluation.

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal Laws and Regulations do not protect any information about a crime committed by a client, either at the program or against any person who works for the program or about any threat to commit such a crime. Federal Laws and Regulations do not protect any information about suspected child abuse or neglect from being reported under Florida State Law to appropriate State or Local Authorities. *(See 42 U.S.C. 290dd-3 and 42 U.S.C.290ee-3 for Federal laws and 42 CFR, Part 2 for Federal Regulations)*

CONSENT FOR FOLLOW-UP CONTACT

I understand that Sutton Place Behavioral Health, Inc. may contact me post-discharge for the purposes of obtaining follow-up information.

☐ Yes, I consent to Follow-up ☐ No, I refuse follow-up contact

I consent for post-discharge electronic follow-up at this email address: ____

REVOCATION OF CONSENT FOR FOLLOW-UP

I understand that I have the right to revoke authorization for consent for follow-up contact. Authorization to revoke consent for follow- up contact must be in writing and will be authorized upon completion of the agency revocation form. Upon written notice of revocation, further use or disclosure of protected health information shall cease immediately, except to the extent that the office, facility, program, or employee has acted in reliance upon the authorization or as use or disclosure is otherwise permitted or required by law. The information may only be re-released with the written authorization of the individual, except as required by law.

CONSENT TO ALLOW ELECTRONIC COMMUNICATION OF PROTECTED HEALTH INFORMATION

The client's health information collected and provided by Sutton Place Behavioral Health, Inc., through its web site and through other electronic means to healthcare professionals, schools, and caregivers, is provided only at the consent of the client or authorized caregiver (if the client is a minor). This information is considered Protected Health Information (PHI) and is subject to Federal Laws regarding its collection, storage, and disclosure. Federal Laws (HIPAA) require specific security measures instituted in order that PHI can be communicated through electronic means.

ePRESCRIBE

ePrescribing is defined as a physician/psychiatrist/ARNP's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of client care. ePrescibing greatly reduces medication errors and enhances client's safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions**: Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**: Provides the physician/psychiatrist/ARNP with information about medications the client is already taking to minimize the number of adverse drug events.
- **Fill status notification:** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the client's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Sutton Place Behavioral Health, Inc. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent and authorize Sutton Place Behavioral Health, Inc. to access, review, and transmit health information electronically. This consent is subject to revocation by the undersigned at any time. In the event that consent has not been revoked, it will expire as designated on the signed Release of Information form. Should information disclosed under this consent be disclosed to others by the client, it is no longer considered Protected Health Information covered under this consent.

I CERTIFY THAT ALL RULES AND POLICIES FOR CLIENT PARTICIPATION AT SUTTON PLACE BEHAVIORAL HEALTH, INC. HAVE BEEN READ BY ME. I UNDERSTAND THEM AND AGREE TO FOLLOW THEM.

______________________________	______________________________
Client Signature	Date
______________________________	______________________________
Parent / Responsible Party Signature	Date
______________________________	______________________________
Witness	Date

Sutton Place Behavioral Health, Inc.
AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAY BE RETURNED TO YOU FOR COMPLETION

❑ **371015 Eastwood Road** **Hilliard, FL 32046** **(904) 845-7777 Fax (904) 845-7621**	❑ **463142 State Road 200** **Yulee, FL 32097** **(904) 225-8280 Fax (904) 225-8232**

1. Identity:

Client Name:	Social Security Number:
Address:	Date of Birth:
	Phone Number:

2. Sender and Receiver:
I hereby authorize Sutton Place Behavioral Health, Inc. to:

❑ Release to ❑ Obtain from

From: (Facility to Disclose Records)	Disclose To:

3. What to disclose: Please check the records you would like disclosed:

❑ Physician's Progress Notes	❑ Bio-psychosocial Assessment	❑ Behavioral observation	❑ Psychiatric Evaluation(s)
❑ Treatment Plan(s)	❑ Transition/discharge summary	❑ Educational information	❑ Urine results
❑ HIV/AIDS information	❑ Legal	❑ Progress Notes	❑ Medications
❑ Labs			❑ History of Medications

4. How disclosure may occur (check all that apply): ❑ Written ❑ Electronic ❑ Verbal ❑ Fax ❑ Audio

5. Timeframe: I would like records from the following dates: ________________________ through ____________________________.

6. Disclosure of special protected records: I specifically authorize the disclosure of information pertaining to:

A. The diagnosis or treatment of drug and/or alcohol abuse. ❑ Yes ❑ No/NA

B. Treatment and/or consultation for mental health and/or psychiatric disorders. ❑ Yes ❑ No/NA

7. Purpose of Use/Disclosure: Please indicate/describe each authorized purpose of the use or disclosure:
❑ To assist/inform clients performance and progress ❑ To evaluate treatment ❑ Other: ____

8. Expiration date: I understand that I may revoke this authorization at any time; My revocation must be submitted in writing at the Facility/location where I originally submitted/filed this authorization; and the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the authorization.

This release shall be valid for (check one):
❑ A single disclosure
❑ A continuing disclosure for 90 days from signature date below
❑ A continuing disclosure for the duration of the client's treatment from signature date below
❑ A continuing disclosure for 1 year from the signature date below
❑ I revoke this authorization as of: ____

9. Consent: I have read and understand this information. I have received a copy of this form and I am the client or am authorized to act on behalf of the client to sign this document verifying authorization for the use or disclosure of the Protected Health Information under the above stated terms.

___________________________________ ___________________________________
Date Client's signature

____
Signature of Legal Representative and Relationship to Client

If client is unable to sign, secure consent of Legal Representative and indicate reason: ❑ Minor ❑ Incompetent ❑ Deceased
Proof of designation must be filed in the chart or sent with this request.

____
Signature of Witness

TO RECEIVING AGENCY OR PERSON

PROHIBITION OF DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR-Part 2) prohibits you from making any further disclosure of it without the specific consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Client Name	**CID#**

463142 SR 200 - Yulee, FL 32097 - (904) 225-8280 Fax (904) 225-8232

Medical History and Physical Health Screening

Instructions:

1. Please fill out as completely as possible.
2. Do not state "NA" (not applicable).
3. Don't draw lines in #VII. Each item must be checked.
4. List medications with strength and frequency of dosage.

Date: _________ Name: ___________________________________ Age: ____ DOB: __________

Weight: __________ Height: __________ Sex: ______

Race: White______ Black____ Hispanic______ American Indian______ Other (Specify)______

Who referred you to Sutton Place? ____

Reason for your referral or visit to Sutton Place: ____

____

I. ALLERGIES

*Drug Allergies or Adverse Reactions - Please list:

(e.g., penicillin) ____

____

____

*Other Significant Allergies - Please list: ____

(e.g., pollen) ____

II. SERIOUS INJURIES - Please list nature of injury and approximate date:

____

____

____

III. SERIOUS ILLNESSES - Please list the problem and the approximate date of diagnosis:

____

____

____

IV. MAJOR SURGERY - Please list surgery performed and approximate date:

____

____

____

Client Name:	**CID #**

V. MEDICATIONS:

*Current Prescription Medications:

Name of Drug	Strength (mgm)	Frequency (# of times per day)

*Non-Prescription Medications Taken Regularly:

Name of Drug	Strength (mgm)	Frequency (# of times per day)

VI. IMMUNIZATIONS (CHILDREN/ADOLESCENTS ONLY)

*Are Immunizations Current? Yes______ No______

*If "No", please list those not current, if you know them. ____________________________________

____

____

____

VII. MEDICAL HISTORY REVIEW

CONDITION OR PROBLEMS WITH:	NEVER HAD	HAD IN PAST	PRESENTLY HAVE	CURRENTLY UNDER PHYSICIAN'S CARE (LIST NAME)
Teeth/Mouth/Throat				
Vision/Eyes (Other Than Glasses)				
Glaucoma				
Difficulty Hearing/Hearing Aid				
Thyroid Problems				
Chronic Dizziness				
Asthma				
Emphysema				
Tuberculosis				
Other Lung Disease				
High Blood Pressure				
Angina				
Heart Attack				
Irregular Heart Beat				
Other Heart Disease				
Chronic Indigestion				
Stomach Ulcers				

Client Name:	CID#:

CONDITION/PROBLEM	NEVER HAD	HAD IN PAST	PRESENTLY HAVE	UNDER PHYSICIAN'S CARE
Chronic Constipation or Diarrhea				
Blood In Stools				
Hepatitis				
Other Liver Disease				
Diabetes				
Insulin Dependent - No ________ Yes ________				
Kidney/Bladder Disease				
Sexually Transmitted Disease				
HIV/AIDS				
Concussion				
Other Serious Head Injury				
Seizure Disorder				
Unexplained Loss of Consciousness				
Meningitis				
Encephalitis				
Other Neurological (Nervous System) Disorder				
Arthritis				
Other Bone or Joint Problem				
Eating Disorders (Anorexia, Bulimia, Compulsive Overeating)				
Cancer If "yes" what type:				

Gynecologic History (Females Only)

Age of Onset of Menstrual Period: ____________

Still Having Period:

Yes ________ - How Often? ___________

No ________ - At What Age Did Period Stop? ___________

Any Unexplained Vaginal Bleeding - Yes_______ No________

Are You Pregnant - Yes_______ Due Date: _________________ No_______

If Pregnant, Under Dr.'s Care - Yes_____ No_____

VIII. SOCIAL HISTORY

Tobacco Use - Current: *Yes_____ No_____

*If yes, do you smoke: Cigarettes _____ Packs per day _____

Cigars _____ # per day _____

Smokeless Tobacco _____ # per day _____

Past: Yes_____ No_____ If yes, how long ago did you quit - years. ________

Client Name:	CID#:

*Alcohol - Current: Yes_____ No_____ If yes, how many drinks (beers, glasses of wine, cocktails) per day ________________.

Past: Yes_____ No_____ If yes, how long since you've used alcohol. ____________________

Would you describe yourself as ever having a drinking problem? Yes_____ No____

If yes, please describe: ____

____

____

____

____

*Illegal Drugs - Current: Yes_____ No_____

If yes, please describe type and frequency of us.

____

____

____

____

Past: Yes _____ No_____

If yes, please describe type and frequency of us.

____

____

*Coffee, Tea and Cola Drinks: How many per day. _____________

*Hobbies - What do you do for recreation? Please describe.

____

____

____

____

*Exercise - Describe type and frequency.

____

____

____

____

*Sleep - Average hours per night. __________

IX. FAMILY HISTORY

*Father - Living_____ Deceased______ Cause of Death______________________________

*Mother - Living_____ Deceased______ Cause of Death______________________________

*Siblings (Brothers and Sisters) - # Living ___ #Deceased ___ Cause of Death(s) ____________

Client Name:	**CID#:**

*Family History of Serious Physical/Mental Illness? Please Describe.

____

____

____

X. NAME, ADDRESS AND PHONE NUMBER OF FAMILY PHYSICIAN OR CLINIC WHERE YOU RECEIVE ROUTINE MEDICAL CARE. IF NONE, SO STATE.

____

____

XI. I DO ___ I DO NOT___ authorize Sutton Place Behavioral Health to furnish information to my Primary Care Physician concerning my treatment at Sutton Place.

Client's Signature ______________________ **Date** ______________________

Relationship to Client ______________________ **Check if legal guardian of client**

Witness Signature ______________________ **Date** ______________________

CLINICIAN OR STAFF RECOMMENDATION/SUMMARY

*Are there significant MEDICAL (non-psychiatric) problems which need to be addressed by the client or which require referrals or continuing medical care. No____ Yes____ (If yes, please describe)

____

____

____

*If referral needed, have you made it? Yes___ No___ To Whom ____________________________

Staff Signature ______________________ Date ______________________

Staff Name (Please Print) ______________________

MEDICAL DIRECTOR REVIEW - BASED ON CLIENT SUPPLIED HISTORY ABOVE.

*No medical referral needed _______

*Medical referral indicated _______

~Referral made by Clinician _______

~Referral not made by Clinician _______ - Needs to be made ____________

*Continue with current medical care _______

Medical Director's Signature ______________________ Date ______________________

H.S. Turner, MD

Client Name:	**CID#:**

Sutton Place Behavioral Health, Inc.
Acknowledgement of Receipt of Notice of
Privacy Practices and Consent Form

I acknowledge the receipt of the Notice of Privacy Practices of Sutton Place Behavioral Health, Inc.

I consent to the use and the disclosure of protected health information about me for treatment, payment, and health care operations as described in the Notice of Privacy Practices.

This means that information about my health will be used by the staff of Sutton Place Behavioral Health, Inc. or disclosed to other people or organizations whenever needed to:

- ⇨ Provide treatment to me or arrange for treatment by another health care provider;
- ⇨ Arrange for payment for services to me;
- ⇨ Operate the business of Sutton Place Behavioral Health, Inc.; and
- ⇨ Enable other health care organizations provide treatment to me or pay for services to me to review the quality and appropriateness of care I receive and conduct other health care operations.

I understand that information disclosed pursuant to this consent may not be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules (42 CFR-Part 2) and state laws for protection of the privacy of your health information. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A written and signed revocation may be submitted at any time, but Sutton Place Behavioral Health, Inc. shall not be held liable for any information released prior to its receipt. Your Authorization for Release of Information may be valid for:

- ⇨ A single disclosure;
- ⇨ 90 continuing days from the signature date;
- ⇨ The duration of your treatment from the signature date; or
- ⇨ One continuous year from the signature date.

You must check the correct box on your Authorization for Release of Information to designate your preference.

I am the person who is the subject of the health records that will be used or disclosed. I agree to the use and the disclosure of my health information as described in this consent.

______________________________________ ____________________

Signature Date

I am the personal representative of the person who is the subject of the health records maintained by Sutton Place Behavioral Health, Inc. My relationship to that person is __________________.
I agree to the use and the disclosure of the health information as described in this consent.

______________________________________ ____________________

Signature of Personal Representative Date

(09-11-03)

Client Questionnaire

Client Name: ______________________________ Date: ______________ CID# __________

Days spent in the community in the last 30 days? _______
Does not include days in inpatient, residential treatment, detox, hospitalization or incarcerated

Residential Status

1	Independent Living-Alone	10	Hospital
2	Independent w/Relatives (Shares cost)	11	Nursing Home
3	Independent w/Non-Relatives (Shares cost)	12	Supported Housing
4	Dependent w/Relatives (does not share cost)	13	Correctional Facility
5	Dependent w/Non-Relatives (does not share cost)	14	DJJ Facility
6	Assisted Living Facility	15	Crisis residence
7	Foster Care/Home	16	Children residential tx facility
8	Group Home	17	Limited Assisted Living Facility
9	Homeless		

County of Residence: ____Nassau____Duval____Baker ____Camden Other:________

Have you attended any self help/support group meetings in the last 30 days?

1	No attendance	4	8-15 times
2	1-3 times	5	16-30 times
3	4-7 times	6	some attendance, #unknown

Have you been arrested in the last 30 days? ____No ____Yes # of times: ____

Are you receiving $4 medications through our Indigent Drug Program? ____No____Yes
Are you receiving sample medications through a Patient Assistance Program? ____No____Yes

Employment Status

30	Full Time	70	Terminated/Unemployment
40	Part Time	81	Homemaker
50	Leave of Absence	82	Student
60	Retired	83	Disabled

Primary Income Source (for Adults)

1 Salary/Wages	4 Disability
2 Welfare	5 Other: ________
3 Retirement	6 None
3 Pension/Social Security	

Adult Clients Only
Total days worked for pay in last 30 days? _____
Total monthly income from paid employment in last 30 days?_____
Total monthly income received from Social Security/Disability in the last 30 days? _____
Total monthly incomes received from other sources in last 30 days? _____

Child Clients Only
Total school days attended in last 30 days? _____
Has child been suspended in last 30 days? _____
Has child been expelled in last 30 days? _____
Has child been committed or recommitted to DJJ in last 90 days? ___YES ___ NO

Adult & Child Clients
Annual Household Income _________ (*Total income earned by client and/or spouse or parents/guardians)*

Sutton Place Behavioral Health, Inc.
Help for Today. Hope for Tomorrow.

463142 SR 200 - Yulee, FL 32097 - (904) 225-8280 Fax (904) 225-8232

Client Questionnaire – C/FARS

On a scale of 1 to 9, with 1 being no problem at all, and 9 being extreme problem, please rate yourself in each of the areas below.

1	2	3	4	5	6	7	8	9
No Problem		Slight Problem		Moderate Problem		Severe Problem		Extreme Problem **Requires Hospitalization***

DEPRESSION
May include some or all of the following: Do you feel sad, most of the day, almost every day? Are you having trouble falling asleep or staying asleep? Do you feel like you just don't care anymore? Have you stopped doing things that made you happy? Are you avoiding people? _______

ANXIETY
May include some or all of the following: Do you worry all the time? Do you feel like you can't stop worrying? Do you feel guilty almost every day? Do you have panic attacks? Do you feel you have to do certain activities or you can't function? _______

HYPERACTIVITY
May include some or all of the following: Do you feel like you can't stop yourself from talking? Do you have trouble sitting still? Do you worry about what may come out of your mouth? Do you have trouble focusing and concentrating? _______

THOUGHT PROCESS
May include some or all of the following: Do you hear or see things that other people do not hear or see? _______

COGNITIVE PERFORMANCE
May include some or all of the following: Do you have trouble with your memory? Are you able to see how your behavior effects others? Does it take you time to understand information? _______

MEDICAL/PHYSICAL
May include some or all of the following: Are you currently having medical problems? Do you have a long-term illness? Are you pregnant? Do you have seizures? Do you have bladder control problems? Have you been injured recently? _______

TRAUMATIC STRESS
May include some or all of the following: Have you ever felt that your life was in danger? Do you ever dream about it? Do you have flashbacks? Is this affecting your daily life? _______

SUBSTANCE USE
May include some or all of the following: Do you use illegal drugs? Do you use drugs or alcohol to avoid/escape things? Do you use drugs or alcohol to not worry or feel depressed? If you haven't drunk alcohol for awhile do you feel sick? If you haven't used drugs for awhile do you feel sick? Do drugs and alcohol disrupt your daily life? _______

INTERPERSONAL RELATIONSHIPS
May include some or all of the following: Do you having difficulty making and keeping friends? Do you feel nervous in social situations? _______

FAMILY RELATIONSHIPS (For Adult Client Only)
May include some or all of the following: Do you have problems with your family members? Do you have difficulty with your child? Have you been court ordered into parenting classes? _______

CLIENT NAME CID

463142 SR 200 - Yulee, FL 32097 - (904) 225-8280 Fax (904) 225-8232

Client Questionnaire – C/FARS

On a scale of 1 to 9, with 1 being no problem at all, and 9 being extreme problem, please rate yourself in each of the areas below.

1	2	3	4	5	6	7	8	9
No Problem		Slight Problem		Moderate Problem		Severe Problem		Extreme Problem **Requires Hospitalization***

FAMILY ENVIRONMENT (For Adult Client Only)
May include some or all of the following: Does your family have any problems getting along? Did a family member recently die? Is there a recent divorce, separation, or custody battle? Are you a single parent? Do you have a newborn? Is there any family violence going on? _______

BEHAVIOR IN THE HOME SETTING (For Child Client Only)
May include some or all of the following: Are you having problems with your sister or brother? Do you get in trouble at home for not following directions? Does your family say you are disrespectful? Is there any family violence going on? _______

ADL (Activities with Daily Living) FUNCTIONING
May include some or all of the following: Do you have trouble taking care of yourself (eating, bathing)? Are you able to dress yourself? Can you wash your own clothes? _______

SOCIO-LEGAL
May include some or all of the following: Have you been arrested recently? Are you involved in the court system? _______

WORK OR SCHOOL
May include some or all of the following: Are you at risk for getting fired? Are you often late for work or have missed several days? Have you been fired, laid off, or quit your job? Are you failing your school classes? Have you been suspended or expelled from school? Do you get in trouble with your teachers? Are you often late for school or have you dropped out? _______

DANGER TO SELF
May include some or all of the following: Do you feel like killing yourself? Do you know how and when you would do it? Have you tried to kill yourself in the past? Do you hurt yourself on purpose? _______

DANGER TO OTHERS
May include some or all of the following: Do you threaten other people? Have you physically harmed other people or animals? Have you been arrested for violence? Do you think about harming someone in particular? _______

SECURITY MANAGEMENT NEEDS
May include some or all of the following: Do you need to be monitored because you may hurt yourself or someone else? _______

_______________________________ _______________
Client Signature **Date**

_______________________________ _______________
Therapist Signature **Date**

CLIENT NAME CID

Sutton Place Behavioral Health, Inc.
Notice of Privacy Practices

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

Sutton Place Behavioral Health, Inc. has adopted the following policies and procedures for protection of the privacy of the people we serve.

Our Obligation to You

We at Sutton Place Behavioral Health, Inc. respect your privacy. This is part of our code of ethics. We are required by law to maintain the privacy of "protected health information" about you, to notify you of our legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected health information" means any information that we create or receive that identifies you and relates to your health or payment for services to you.

Use and Disclosure of Information about You

Use and disclosure for treatment, payment, and health care operations.

We will use your protected health information and disclose it to others as necessary to provide treatment to you. Here are some examples:

Various members of our staff may see your clinical record in the course of our care for you. This includes clinical assistants, nurses, physicians, and other therapists.
It may be necessary to send blood or urine samples to a laboratory for analysis to help us evaluate your medical condition.
We may provide information to your health plan or another treatment provider in order to arrange for a referral or clinical consultation.
We will contact you to remind you of appointments.
We may contact you to tell you about treatment services that we offer that might be of benefit to you.

We will use or disclose your protected health information as needed to arrange for payment for service to you. For example, information about your diagnosis and the service we render is included in the bills that we submit to your health insurance plan. Your health plan may require health information in order to confirm that the service rendered is covered by your benefit program and medically necessary. A health care provider that delivers service to you, such as a clinical laboratory, may need information about you in order to arrange for payment for its services.

It may also be necessary to use or disclose protected health information for our health care operations or those of another organization that has a relationship with you. For example, our Quality Improvement staff reviews records to be sure that we deliver appropriate treatment of high quality. Your health plan may wish to review your records to be sure that we meet national standards for quality of care.

Our Policy:

It is our policy to obtain specific written permission for every disclosure of protected health information to third parties. You will be ask to sign an Authorization form for disclosure to each person or organization that receives the information. We will not ask your permission to use or disclose your protected health information for treatment, payment, or health care operations purposes.

Emergencies. If there is an emergency, we will disclose your protected health information as needed to enable people to care for you.

Disclosure to your family and friends. If you are an adult, you have the right to control disclosure of information about you to any other person, including family members or friends. If you ask us to keep your information confidential, we will respect your wishes. But if you don't object, we will share information with family members or friends involved in your care as needed to enable them to help you.

Disclosure to health oversight agencies. We are legally obligated to disclose protected health information to certain government agencies, including the federal Department of Health and Human Services.

Disclosures to child protection agencies. We will disclose protected health information as needed to comply with state law requiring reports of suspect ed incidents of child abuse or neglect.

Other disclosures without written permission. There are other circumstances in which we may be required by law to disclose protected health information without your permission. They include disclosures made:

* Pursuant to court order;
* To public health authorities;
* To law enforcement officials in some circumstances;
* To correctional institutions regarding inmates;
* To federal officials for lawful military or intelligence activities;
* To coroners, medical examiners and funeral directors;
* To researchers involved in approved research projects; and
* As otherwise required by law.

Other disclosures. For alcohol and Drug Abuse programs, we will follow the provisions of 42 CFR Part 2 governing disclosure of protected health information. Except for the circumstances described above, we will not disclose protected health information to a third party without your written permission of the individual or a court order. If a request for disclosure of your patient record is received, you will be contact and asked whether you wish to authorize disclosure. If you refuse to authorize disclosure, or it is not possible for us to contact you personally, we will not disclose your information without a court order.

Disclosures with your permission. No other disclosure of protected health information will be made unless you give written Authorization for the specific disclosure.

Your Legal Rights

Right to request confidential communications. You may request that communications to you, such as appointment reminders, bills, or explanations of health benefits be made in a confidential manner. We will accommodate any such request, as long as you provide a means for us to process payment transactions.

Right to request restrictions on use and disclosure of your information. You have the right to request restrictions on our use of your protected health information for particular purposes, or our disclosure of that information to certain third parties. We are not obligated to agree to a requested restriction, but we will consider your request.

Right to revoke a Consent or Authorization. You may revoke a written Consent or Authorization for us to use or disclose your protected health information. The revocation will not affect any previous use or disclosure of your information.

Right to review and copy record. You have the right to see records used to make decisions about you. We will allow you to review your record unless a clinical professional determines that would create a substantial risk of physical harm to you or someone else. If another person provided information about to our clinical staff in confidence, that information may be removed from the record before it is shared with you. We will also delete any protected health information about other people.

At your request, we will make a copy of your record for you. We will charge a reasonable fee for this service.

Right to "amend" record. If you believe your records contains an error, you may ask us to amend it. If there is a mistake, a note will be entered in the record to correct the error. If not, you will be told and allowed the opportunity to add a short statement to the record explaining why you believe the record is inaccurate. This information will be included as part of the total record and shared with others if it might affect decisions they make about you.

Right to an accounting. You have the right to an accounting of some disclosures of your protected health information to third parties. This does not include disclosures that you authorize, or disclosures that occur in the context of treatment, payment or health care operations. We will provide an accounting of other disclosures made in the preceding six years. If requested by law enforcement authorities that are conducting a criminal investigation, we will suspend accounting of disclosures made to them.

Right to a paper copy of this Notice. You have the right to a paper copy of any Notice of Privacy Practices posted on our web site.

How to Exercise Your Rights

Questions about our policies and procedures, requests to exercise individual rights, and complaints should be directed to our Privacy Officer.

Our Contact Person is Kim Corley. The Contact Person can be reached at (904) 491-2001 extension 422.

Personal representatives. A “personal representative” of a patient may act on their behalf in exercising their privacy rights. This includes the parent or legal guardian of a minor. In some cases, adolescents who are “mature minors” may make their own decisions about receiving treatment and disclosure of protected health information about them. If an adult is incapable of acting on his or her own behalf, the personal representative would ordinarily be his or her spouse or another member of the immediate family. An individual can also grant another person the right to act as his or her personal representative in an advance directive or living will.

Disclosure of protected health information to personal representatives may be limited in cases of domestic or child abuse.

Complaints

If you have any complaints or concerns about our privacy policies or practices, please submit a Complaint to our Contact Person. If you wish, the Contact Person will give you a form that you can use to submit a Complaint if you wish.

You can also submit a complaint to the United States Department of Health and Human Services. Send your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
OCR Hotlines-Voice: 1-800-368-1019

We will never retaliate against you for filing a complaint.

Sutton Place Behavioral Health, Inc.

CLIENT'S RIGHTS

1. I have the right to be treated according to my needs with access to treatment or accommodations that are available or medically indicated, regardless of race, gender, age, national origin, culture, sexual orientation/identity, spiritual beliefs, socioeconomic status, language, or sources of payment for care.
2. I have the right to know the degree and the qualifications of the professional person involved in my treatment.
3. I have the right to be treated with dignity and respect at all times and free from abuse, financial exploitation, retaliation, humiliation, and neglect.
4. I have the right to actively participate in treatment/service plan information and revision.
5. I have the right to include family members and/or significant others in my treatment.
6. I have the right to reasonable safety in the offices of Sutton Place Behavioral Health, Inc.
7. I have the right to be given an explanation of the diagnosis, the nature of illness, and the planned course of my treatment and prognosis.
8. I have the right to be given sufficient information to give an informed consent prior to the start of any treatment procedure, except in an emergency situation.
9. I have the right to refuse treatment and to be informed of the medical and/or legal consequences of this action.
10. I have the right to be seen by a private physician with the understanding that all costs incurred will be borne by me.
11. I have the right to have all information pertaining to my illness and treatment held in strictest confidence by everyone at Sutton Place Behavioral Health, Inc.
12. I have the right to have all information concerning the cost of treatment and to receive an itemized statement at my request.
13. I have the right to initiate a complaint or grievance procedure without retaliation. I understand that I may begin the process by following the steps in the Client Grievance Procedures posted in the lobby or by talking to a Program Team Leader. I have the right to report at any time to the Florida Department of Children & Families at 1-800-96-ABUSE, the Florida Local Advocacy Council (904) 723-2133, the Human Rights Advocacy Committee 1-800-342-0825, or the Advocacy Center for Persons with Disabilities 1-800-342-0823.

CLIENT RESPONSIBILITIES

1. I have the responsibility to actively and earnestly cooperate in my treatment.
2. I have the responsibility to follow all program rules and regulations.
3. I have the responsibility to keep scheduled appointments or to cancel at least 24 hours in advance so that the allotted time may be given to another client.
4. I have the responsibility to pay for treatment in accordance with my ability to pay as agreed during the initial intake or subsequent financial update(s).
5. I have the responsibility to respect the rights of other clients, including their rights to treatment and to confidentiality.
6. I have the responsibility to respect the rights of Sutton Place Behavioral Health, Inc.'s staff and to not communicate with abusive language or make physical threats.
7. I have the responsibility to respect Sutton Place Behavioral Health, Inc.'s property.
8. If I decline to accept medical recommendations of my treatment team, I have the responsibility to sign a release of responsibility releasing Sutton Place Behavioral Health, Inc. from any liability.

CLIENT GRIEVANCE PROCEDURE

All clients receiving services at Sutton Place Behavioral Health, Inc. or an individual acting on his or her behalf have a right to file a grievance as a formal or informal notice of dissatisfaction regarding operation or staff action. All formal complaints must be submitted in writing. The grievance involves a series of steps offering the possibility of satisfactory resolution at each step.

STEP 1: To file a grievance, the client (or person acting on his/her behalf) obtains and completes the Grievance Report Form. Each facility shall have these forms visible in the waiting area or with the front office staff. These forms may also be obtained from any SPBH staff member by asking. The completed form is forwarded to the Program Team Leader.

STEP 2: The Program Team Leader will review the problem and a resolution will be presented to the client in writing within five (5) working days from the date of receipt of the complaint. A written response must be given to the client within 24 hours of disposition. The individual acting on behalf of the client shall be notified of the completion of the investigation, but will not be given specific details of the disposition, unless they have a legal right to the information or a signed release of information is in place.

STEP 3: If this does not resolve the problem satisfactorily, the client or person acting on his/her behalf may seek out the Chief Administrative Officer. An answer from the Chief Administrative Officer will be presented to the client in writing with five (5) working days from the date of receipt of the complaint. A written response must be given to the client within 24 hours of disposition. The individual acting on behalf of the client shall be notified of the completion of the investigation, but will not be given specific details of the disposition, unless they have a legal right to the information or a signed release of information is in place.

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STEP 4: If this cannot resolve the problem satisfactorily, the problem will be referred to the Professional Council. This committee will conduct an investigation and will make its written recommendations to the client within five (5) working days. A decision will be given or mailed to the client within 24 hours of disposition.

STEP 5: If the Professional Council cannot resolve the problem, the client may seek out the Chief Executive Officer. An answer will be presented to the client in writing within five (5) working days.

STEP 6: If the client is not satisfied with the response from the Chief Executive Officer, a written appeal may be submitted to the Board of Directors of Sutton Place Behavioral Health, Inc. The Board of Directors may also consult with its legal counsel. The Board of Directors will respond within thirty (30) working days and will send a copy of its decision to the CEO and the Professional Council. The Chairperson of the Professional Council will provide the Board of Director's written decision to the client either in person or mailed within 24 hours of disposition.

STEP 7: If the client does not agree with the Board of Director's written decision, s/he may contact the Florida Local Advocacy Council at (904) 723-2133, Florida Department of Children and Families Abuse Hotline 1-800-96-ABUSE, Human Rights Advocacy Committee 1-800-342-0825, or the Advocacy Center for Persons with Disabilities 1-800-342-0823, or any other individual or agency <u>at any time</u> during the complaint process to request assistance.

Revised 07-14-10