CLIENT REFERRAL FORM

CLIENT INFORMATION		
Name:	**Date of Birth:**	**Age:**
Gender:	**Marital Status:**	
Race:	**Legal Guardian (Name and Number):**	
SSN:	**Medicaid (MMIS):**	
Provider Name:	**Member ID:**	
Insurance Verified: ☐ **No or** ☐ **Yes**	**Reference Number:**	
Insurance Verified by:		

REFERRAL INFORMATION		
Street Address:	**Address 2:**	
City	**State:**	**Zip Code:**
Phone Number(s):		
Reason for Referral:		
Referred By:	**Contact Number:**	**Referral Date:**
Notes:		

SERVICE LOCATION			
☐ **Akron**	☐ **Cincinnati**	☐ **Cleveland**	☐ **Telemental Health**

LSS STAFF USE ONLY	
Date of Scheduled Evaluation:	**Diagnostic Evaluation with:**
Location of Evaluation: ☐ **Office** ☐ **Home**	
Assign Clinician to Ongoing Psychotherapy ☐ **Yes** ☐ **No**	

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing **Life Solutions South** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Client Financial policies.

Client Financial Responsibilities

- The Client (or Client's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the Client is required to provide the most correct and updated information regarding insurance. If we are unable to process payment through your insurance for any reason we will bill you for the services provided at the following rates:

1.	Individual Psychotherapy	1-hour Session	$ 55.00
2.	Group Psychotherapy	1-hour Session	$ 75.00
3.	Family Psychotherapy	1-hour Session	$ 75.00
4.	Diagnostic Evaluation	Flat fee	$ 50.00
5.	Community Psychiatric Supportive Treatment	1-hour Session	$ 35.00
6.	Therapeutic Behavioral Services	1-hour Session	$ 35.00
7.	Psychosocial Rehabilitation	1-hour Session	$ 35.00
8.	Assertive Community Treatment	1-hour Session	$ 75.00
9.	Intensive Home-Based Therapy	1-hour Session	$ 75.00
10.	Substance Use Disorder Assessment & ASAM	Flat fee	$ 50.00
11.	Substance Use Disorder Services	1-hour Session	$ 35.00
12.	Intensive Outpatient Treatment	Hourly Rate	$ 75.00

- Clients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan
- Copays are due at the time of service
- Coinsurance deductibles and non-covered items are due 30 days from receipt of billing
- Clients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: Charge for returned checks - $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to **Life Solutions South** and any associated healthcare entities for service rendered as allowed under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Client Acknowledgement and Authorization

We respect Client confidentiality and only release personal health information about you in accordance with the State and Federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully. Bu my signature below, I acknowledge that I have received and read the privacy notice provided by **Life Solutions South** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and or other physicians or healthcare entities to participate in my care.

_____

Client Name (Printed)

_____ _____

Client/Parent/Legal Guardian Signature **Date**

ACKNOWLEDGEMENT RECEIPT OF:

1. Consumer Rights Policy and DMH Consumer Rights Statement; and
2. HIPAA Privacy Rules for the Protection of Health and Mental Health Information

I acknowledge that I received:

_____ Consumer Rights Policy and DMH Consumer Rights Statement

_____ HIPAA Privacy Rules for the Protection of Health and Mental Health Information

My signature below acknowledges that I have received a copy of both the Life Solutions South, LLC. **Consumer Rights Policy** and the **DMH Consumers Rights Statement** and that I have received a copy of the **HIPAA Privacy Rules for the Protection of health and Mental Health Information**.

Client Name (Printed): _____

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

Reason for Refusal to sign:

_____

_____

_____

_____

STATEMENT OF PROVIDE CHOICE

I,_____ (Parent/Legal Guardian, if minor) have selected to receive the following service(s) from **Life Solutions South**:

Check all that Apply:

_____ Diagnostic Evaluation and Diagnostic Evaluation Update

_____ Community Psychiatric Service Treatment (CPST)

_____ Psychotherapy (Individual, Family, Group, Crisis)

_____ Psychoeducation Support Services (Therapeutic Behavioral Services, Psychosocial Rehabilitation)

_____ Assertive Community Treatment (ACT)

_____ Intensive Home-Based Therapy (IHBT)

_____ Substance Use Disorder Assessment and ASAM

_____ Substance Use Disorder Services (Case Management; Psychotherapy; Individual Counseling; Group)

_____ Intensive Outpatient Treatment

_____ Laboratory Analysis

I attest that I have been provided with the information necessary to make an informed choice about service, informed about the range of other services in a way that in non-coercive and protects my right to self-determination.

My selection of a service provider was based solely upon my identified needs, diagnosis, preference, and provider availability.

By signing this Statement of Provider Choice, I acknowledge that I was given choice of provider and that the screening discussed location, available times, specialty, culture and linguistic preferences with me.

_____

Client Name (Printed)

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian Signature **Date**

AUTHORIZATION TO RELEASE AND/OR EXCHANGE CONFIDENTIAL INFORMATION

Client Name | Date of Birth

Social Security Number (last four digits) | Phone Number

I, the undersigned, hereby authorize Life Solutions South to use or disclose my personal health information and/or confidential information as described below to:

Name of Recipient | Phone | Fax

Address (Street) | (City) (State) | (Zip)

☐ If marked, I further authorize the **EXCHANGE** of information and for the party identified as Recipient above to also disclose my personal health information and/or confidential information to Life Solutions South.

Type of Information to be Released/Exchanged:

☐ Mental Health Assessments/Evaluations
☐ Treatment Plan/ITP/Treatment Updates
☐ Progress Notes
☐ Psychological Information
☐ General Medical Records
(except HIV/AIDS related diagnosis and treatment)
☐ Other (specify):

☐ Partial Hospitalization Records
☐ HIV/AIDS Related Diagnosis
☐ Court Reports
☐ Psychiatric Information
☐ Employment Records
☐ School Reports/Records/IEPIMFE
☐ Discharge Summary

☐ Alcohol/Drug Assessment (LOC)
☐ Alcohol/Drug Treatment Summary
☐ Alcohol/Drug Treatment Plan
☐ Alcohol/Drug Progress Notes
☐ Alcohol/Drug Discharge Plan
☐ Urinalysis/Breathalyzer Results

Dates of Service to Release (FROM): _____ **(TO):** _____

Purpose for Disclosure:

☐ Care/Treatment/Ongoing
☐ Assessment/Evaluation
☐ Continuity of Care

☐ Treatment Planning
☐ To follow up on a referral
☐ Other, please specify: _____

(purpose for disclosure must be completed prior to processing, e.g., continuity of care, personal use, legal)

I understand and acknowledge that the requested information may contain information regarding physical and mental illness, HIV test results or diagnosis, AIDS or AIDS related conditions, alcohol and/or drug dependence/abuse*. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

I understand that I may see and copy the information described on this form if requested in writing. I also understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

I understand I have a right to revoke this authorization (in writing) at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. If not revoked, **this authorization will expire one year from the date written below** or on the following date, event or condition (if earlier): _____.

AUTHORIZATION TO RELEASE AND/OR EXCHANGE CONFIDENTIAL INFORMATION

I understand there may be charges for the copying and release of information and accept financial responsibility for those charges. I understand and agree that a copy of this authorization shall have the same force and effect as the original.

Signature of Client	Printed Name	Date

Signature of Parent/Legal Guardian/ Personal Representative**	Printed Name	Date

** Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute and alcohol or drug abuse client. ** If other than client's signature, a copy of legal paperwork verifying the client's personal representative MUST accompany the request unless otherwise on file with provider (e.g., court appointed guardian, durable power of attorney for healthcare, grandparent power of attorney). Exception: Parent signing for client under the age of eighteen and the County agency holding custody.*

Revocation of Authorization for Release of Information

At the date and time noted below, I hereby revoke permission for Life Solutions South to further release information to the above-noted person, except to the extent the program has already acted in reliance upon it.

Signature of Client/Parent/Legal Guardian/Personal Representative**	Date

CONSENT FOR TREATMENT
(18 yrs and older)

Client Name _____

Date of Birth _____ **Last Four of SS#** _____

I/We hereby give consent for mental health treatment (which may include services, supports) for the above-named Consumer. Services may include one or more of the following:

1. **Diagnostic Evaluation and Diagnostic Evaluation Update**
2. **Community Psychiatric Service Treatment (CPST)**
3. **Psychotherapy (Individual, Family, Group, Crisis)**
4. **Psychoeducation Support Services (Therapeutic Behavioral Services, Psychosocial Rehabilitation)**
5. **Assertive Community Treatment (ACT)**
6. **Intensive Home-Based Therapy (IHBT)**
7. **Substance Use Disorder Assessment and ASAM Level of Care**
8. **Substance Use Disorder Services (Case Management; Psychotherapy; Individual Counseling; Group)**
9. **Intensive Outpatient Treatment**
10. **Laboratory Analysis**
11. **Medication Management**

I understand that all information shared with service providers at Life Solutions South is confidential and no information will be released without my consent. During the course of treatment at Life Solutions South, it may be necessary for my service provider to communicate with providers at **Life Solutions South**. While written authorization will not be requested, prior to any discussion with **Life Solutions South** providers, I understand that only provider will discuss all communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the service provider is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the provider is legally required to take steps to protect the child and to inform the proper authorities.
C. When a valid court order is issued for medical records, the provider and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at **Life Solutions South**, I may discuss them with my provider or the Clinical Supervisor. I have read and understand the above. I consent to receive the treatment offered to me by **Life Solutions South**. I understand that I may stop treatment at any time.

The consent/or treatment process has been thoroughly explained to me and I understand that I may stop treatment at any time.

Client Name (Printed): _____

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

CONSENT FOR TREATMENT
(Minor)

Client Name _____

Date of Birth _____ **Last Four of SS#** _____

As the parent or legal guardian with the authority to consent on behalf of the consumer named above, I hereby give my consent to receive behavioral health treatment (which may include services, supports, and/or medication) for the above named Consumer. Services may include one or more of the following:

1. **Diagnostic Evaluation and Diagnostic Evaluation Update**
2. **Community Psychiatric Service Treatment (CPST)**
3. **Psychotherapy (Individual, Family, Group, Crisis)**
4. **Psychoeducation Support Services (Therapeutic Behavioral Services, Psychosocial Rehabilitation)**
5. **Assertive Community Treatment (ACT)**
6. **Intensive Home-Based Therapy (IHBT)**
7. **Substance Use Disorder Assessment and ASAM Level of Care**
8. **Substance Use Disorder Services (Case Management; Psychotherapy; Individual Counseling; Group)**
9. **Intensive Outpatient Treatment**
10. **Laboratory Analysis**
11. **Medication Management**

I understand that all information shared with service providers at Life Solutions South is confidential and no information will be released without my consent. During the course of treatment at Life Solutions South, it may be necessary for my service provider to communicate with providers at **Life Solutions South**. While written authorization will not be requested, prior to any discussion with **Life Solutions South** providers, I understand that only provider will discuss all communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the service provider is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the provider is legally required to take steps to protect the child and to inform the proper authorities.
C. When a valid court order is issued for medical records, the provider and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at **Life Solutions South**, I may discuss them with my provider or the Clinical Supervisor. I have read and understand the above. I consent to receive the treatment offered to me by **Life Solutions South**. I understand that I may stop treatment at any time.

The consent/or treatment process has been thoroughly explained to me and I understand that I may stop treatment at any time.

Client Name (Printed): _____

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

PHOTO RELEASE FORM

Permission to Use Photograph

Client Name _____

Date of Birth _____ **Last Four of SS#** _____

I,_____ (Parent/Legal Guardian, if minor) grant to **Life Solutions South**, its representatives and employees the right to take photographs of me in connection with any activities I may participate in connected with services offered by **Life Solutions South**. I authorize **Life Solutions South**, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that **Life Solutions South** may use such photographs of me with / without (circle one) my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above:

_____

Client Name (Printed)

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian Signature **Date**

CONSENT TO TELE-MENTAL HEALTH

Client Name _____

Date of Birth _____ **Last Four of SS#** _____

Introduction
Tele-mental health is the form of telemedicine that allows clients to access mental health care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health care by enabling a client to remain in his/her home or office.
- Improved convenience for the client.
- More efficient management of mental health care within the community setting.
- Obtaining expertise of a distant specialist.

Possible Risks:
As with any medical procedure, there are potential risks associated with the use of tele-mental health. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for the effective communication between the client and the mental health professional. Effective communication is vital to the provision of mental health services by the mental health professional;
- Cultural and/or language differences between the client and the mental health professional may affect communication and service delivery.
- Delays in mental health assessment and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in judgmental errors by the mental health professional;

Please initial after reading this page: _____

CONSENT TO TELE-MENTAL HEALTH

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to tele-mental health and that no information obtained in the use of tele-therapy which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of tele-mental health in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a tele-mental health interaction and may receive copies of this information for a reasonable fee.
4. I understand that no video and/or audio recordings of tele-mental health sessions will be made.
5. I understand that a variety of alternative methods for the provision of mental health services may be
    a. available to me, and that I may choose one or more of these at any time.
6. I understand that an alternative method for the provision of mental health services may be used by my
    a. mental health professional when deemed necessary.
7. I understand that it is my duty to inform my mental health professional of any other healthcare providers involved in my medical/ mental health care.
8. I understand that I may expect the anticipated benefits from the use of tele-mental health in my care, but that no results can be guaranteed or assured.
9. I understand that Life Solutions South cannot ensure confidentiality at the site where the client is located and when unapproved equipment software is used by the client, when tele-mental health procedures are not followed by the client.
10. I understand that Life Solutions South is not responsible for overages on client data usage plans, when Wi-Fi is not used by the client.
11. I understand that my mental health professional providing tele-mental health is a qualified mental health professional with specialized training in the provision of distance mental health.
12. I understand that Life Solutions South Headquarters is located at 2728 Euclid Avenue, Suite 400, Cleveland, OH 44115; phone number: 216-600-5194.
13. I understand that in times of crisis, or as desired during business hours, I may reach my mental health professional by business cell or desk phone.
14. I understand that in times of crisis outside of normal work hours of my mental health professional I may call the Mobile Crisis Hotline at 234-334-1880 or call 911.

Client Consent to the Use of Tele-Mental health

I have read and understand the information provided above regarding tele-mental health, have discussed it with my mental health professional as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-therapy in my medical care. I hereby authorize Life Solutions South to use tele-mental health in the course of my mental health diagnosis and treatment.

Client Signature: _____ _____

Date

Parent/Legal Guardian Signature: _____ _____

Date

TRANSPORTATION PERMISSION SLIP

This permission slip must be signed by the parent or guardian of the child. If you do not give permission, please indicate in the appropriate space of the form.

Client Name: _____

TO BE SIGNED BY PARENT/GUARDIAN

I hereby give my full permission to Life Solutions South to have consumer named above transported.

_____

Client Signature Date

_____

Parent/Legal Guardian Signature Date

I do **NOT** give permission to Life Solutions South to have consumer named above transported.

_____

Client Signature Date

_____

Parent/Legal Guardian Signature Date