



CHILD / ADOLESCENT CLIENT INFORMATION FORM

Client Information							
Medicaid ID#:		APS ID#:		Date:		Intake Staff:	
First Name:			Middle Name:			Last Name:	
Age:	Date Of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		S.S.#		County:
Spouse Full Name:				Date Of Birth:		S.S.#:	
Current Address:						Apt #	
City:				State:		Zip Code:	
Home Phone:		Fax:		Alternate:		Email Address:	
Race: <i>(Choose only one)</i> <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Multiracial <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander					Ethnicity: Hispanic/Latino Origin <input type="checkbox"/> Yes <input type="checkbox"/> No		
					Number of Individuals in Household:		
Marital Status: <input type="checkbox"/> Single Never married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed						Monthly Household Income:	
Payor/Funding Source: <i>(Present Document of Proof of Insurance, etc (card and/or policy #)</i> <input type="checkbox"/> Self Pay <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DJJ <input type="checkbox"/> DFACS <input type="checkbox"/> CMO <input type="checkbox"/> Private Insurance <input type="checkbox"/> State Contract Svcs. <input type="checkbox"/> Medicaid Wavier <input type="checkbox"/> If private, please specify:						At Risk of Homelessness <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Family Members: Mother: _____ Age: ____ Father: _____ Age: ____ Sibling: _____ Age: ____ 2. _____ Age: ____ 3: _____ Age: ____							
Insurance Information: Name of Primary Insurance Company: _____							
Address:				State:		Zip:	
Phone No:		Group No:				Policy No:	
Secondary Insurance Co:				Phone:		Policy/Group No:	
Referral Source: (check all that apply)						English Proficiency:	
<input type="checkbox"/> Self		<input type="checkbox"/> Family or Relative		<input type="checkbox"/> Access/Crisis Line		<input type="checkbox"/> Proficient <input type="checkbox"/> Limited-Spanish	
<input type="checkbox"/> School		<input type="checkbox"/> Judge or Court		<input type="checkbox"/> Probation Officer		<input type="checkbox"/> Group Home	
<input type="checkbox"/> DFACS		<input type="checkbox"/> DJJ		<input type="checkbox"/> State Hospital		<input type="checkbox"/> Law Enforcement	
<input type="checkbox"/> Foster Home		<input type="checkbox"/> Concern Individual		<input type="checkbox"/> General Hospital		<input type="checkbox"/> Other (specify)	
						<input type="checkbox"/> Primary Language <input type="checkbox"/> Limited - Primary Language Other	
Communication: <input type="checkbox"/> No Impairment Noted <input type="checkbox"/> Single Words or Gestures <input type="checkbox"/> American Sign Language <input type="checkbox"/> Utilizes Language Technology							
Special Population: <input type="checkbox"/> Vision Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Pregnant <input type="checkbox"/> Veteran <input type="checkbox"/> SSI/Disabled <input type="checkbox"/> IV/Drug User <input type="checkbox"/> HIV <input type="checkbox"/> None							
Living Situation: <input type="checkbox"/> Private Residence <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Homeless not in Shelter <input type="checkbox"/> Residential Care <input type="checkbox"/> Foster Home <input type="checkbox"/> Jail/Correction Facility <input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF) <input type="checkbox"/> Institutional Care/Nursing Home <input type="checkbox"/> Other:							
Child/Adolescent School Setting: <input type="checkbox"/> Enrolled in Mainstream School <input type="checkbox"/> Enrolled in Psycho-Education Center <input type="checkbox"/> Enrolled in Home School <input type="checkbox"/> Enrolled in Alternative School <input type="checkbox"/> Enrolled in a Technical School <input type="checkbox"/> Not Enrolled in School <input type="checkbox"/> Other:							
Child and Adolescent: Number of days absent from school in past month:					Highest grade completed by child:		
Legal Involvement: <input type="checkbox"/> DFACS <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Treatment Court <input type="checkbox"/> Adult Probation <input type="checkbox"/> Probate Court <input type="checkbox"/> Jail/Law Enforcement <input type="checkbox"/> Parole <input type="checkbox"/> Adult Criminal Court						Arrest: Number of arrests, regardless of nature of offense or outcomes, in the past 30 days:	
Legal Custody: <input type="checkbox"/> DFACS <input type="checkbox"/> DJJ <input type="checkbox"/> Other Court-Appointed Guardian <input type="checkbox"/> Biological Parent <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other:							
Justice System Involvement: Has consumer been involved with criminal/justice system in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include arrest, probation, parole, commitments, adjudications, diversions, or awaiting sentencing: _____							
Name of Probation Officer:				Contact #:			
Employment: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other:						Date Employed:	
Hourly or Weekly Wage:		Name of Employer:				Weekly hours worked:	
What kind of problem brings you to Positive Growth Counseling Center?							
How long has this problem persisted?				Under what condition do your problems get worse? / better?			

Type of Substance(s) Used:	<input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both		
Name of Substance(s) Used:	Indicate the name of substances used/abused:		
	Primary Substance Used	Secondary Substance Used	Tertiary Substance Used
Route of Administration:	<input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> Oral <input type="checkbox"/> Injection
	<input type="checkbox"/> Smoking <input type="checkbox"/> Other	<input type="checkbox"/> Smoking <input type="checkbox"/> Other	<input type="checkbox"/> Smoking <input type="checkbox"/> Other
	<input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown	<input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown	<input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown
Frequency of Use:	<input type="checkbox"/> Daily	<input type="checkbox"/> Daily	<input type="checkbox"/> Daily
	<input type="checkbox"/> 1-2 times in the past week	<input type="checkbox"/> 1-2 times in the past week	<input type="checkbox"/> 1-2 times in the past week
	<input type="checkbox"/> 3-6 times in the past week	<input type="checkbox"/> 3-6 times in the past week	<input type="checkbox"/> 3-6 times in the past week
	<input type="checkbox"/> 1-3 times in the past month	<input type="checkbox"/> 1-3 times in the past month	<input type="checkbox"/> 1-3 times in the past month
Age at first use:			
Prior Treatment Episodes	How many previous treatment episodes has the consumer received in any drug or alcohol program?		
Tobacco Use(s)	How often do you smoke? <input type="checkbox"/> Daily <input type="checkbox"/> Once a Week <input type="checkbox"/> Two or more times week <input type="checkbox"/>		At what age did you start smoking?

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotion Abuse				Legal Problems			
Sexual Abuse				Multiple Family Move			
Physical Abuse				Homelessness			
Neglect Abuse				Military Family			
Family Violence				Discrimination			
Substance Abuse				Anger Issues			
Serious Illness				School Issues			
Accident or Injury				Gambling Issues			

(Do Not Write In This Section - This section will be completed with a Clinician)

<input type="checkbox"/> SUICIDAL <input type="checkbox"/> HOMICIDAL: <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> MENTAL HEALTH <input type="checkbox"/> DRUG USE <input type="checkbox"/> LEGAL <input type="checkbox"/> Not Relevant							
Risk Assessment/Admission Priority:							
<input type="checkbox"/> HIGH RISK (Emergent / Immediate-within 1 hour) <input type="checkbox"/> Acute Illness – requires immediate hospitalization <input type="checkbox"/> History of multiple psychiatric admissions <input type="checkbox"/> Medications requiring frequent monitoring <input type="checkbox"/> Suicidal or Homicidal <input type="checkbox"/> Active substance abuse				<input type="checkbox"/> LOW RISK (Routine / within 10 days) <input type="checkbox"/> No previous psychiatric history <input type="checkbox"/> No history of suicide attempts <input type="checkbox"/> Diagnostic Impression/ No psychosis or severe mood disorder			
<input type="checkbox"/> MODERATE RISK (Urgent / within 48 hours) <input type="checkbox"/> History of psychiatric illness, but stable on medications <input type="checkbox"/> No threat to self or others <input type="checkbox"/> Substance abuse by history – no current usage				Comments:			
OVERALL RISK / PRIORITY: <input type="checkbox"/> HIGH / Immediate <input type="checkbox"/> MODERATE / <48 Hours <input type="checkbox"/> LOW / < 10 days							
Has the individual seeking services previously received Mental Health and/or Substance Abuse Services? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, we whom:							
Medications Current Medication: <input type="checkbox"/> None <input type="checkbox"/> Psychotropic <input type="checkbox"/> Medical <input type="checkbox"/> Other:							
Does consumer follow medication regime? <input type="checkbox"/> Yes <input type="checkbox"/> No				Prescribing Physician (indicate if PCP or Psychiatrist):			
Name of Medication		Current Dosage/Frequency		Start Date		Side Effects	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Symptoms: (Please check all that currently apply. Those not checked are assumed absent).							
<input type="checkbox"/> Depressed Mood		<input type="checkbox"/> Disruption of Thought Process/Content		<input type="checkbox"/> Emotional/Physical/ Sexual Trauma Victim		<input type="checkbox"/> Emotional/Physical/ Sexual Trauma Perpetrator	
<input type="checkbox"/> Decreased Energy						<input type="checkbox"/> Concomitant Medical Condition	
<input type="checkbox"/> Grief	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Worthlessness	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Anxiousness	<input type="checkbox"/> Elevated Mood	<input type="checkbox"/> Anger/Aggression
<input type="checkbox"/> Guilt	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Delusions	<input type="checkbox"/> Impulsiveness	<input type="checkbox"/> Irritability	<input type="checkbox"/> Oppositional	<input type="checkbox"/> Obsession/Compulsion
<input type="checkbox"/> Shy	<input type="checkbox"/> Friendly	<input type="checkbox"/> Helpful	<input type="checkbox"/> Precise	<input type="checkbox"/> Shallow	<input type="checkbox"/> Outgoing	<input type="checkbox"/> Overweight	<input type="checkbox"/> Underweight
<input type="checkbox"/> Irritable	<input type="checkbox"/> Proud	<input type="checkbox"/> Weak	<input type="checkbox"/> Distant	<input type="checkbox"/> Low Self Esteem	<input type="checkbox"/> Lost	<input type="checkbox"/> Self Doubting	<input type="checkbox"/> Overwhelmed
<input type="checkbox"/> Sarcastic	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Dependable	<input type="checkbox"/> Hopeful	<input type="checkbox"/> Tough Skinned	<input type="checkbox"/> Short Fused	<input type="checkbox"/> Defiant	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> Guilty	<input type="checkbox"/> Passive	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Grieving	<input type="checkbox"/> Empty	<input type="checkbox"/> Sad	<input type="checkbox"/> Distance	<input type="checkbox"/> Poor Concentration

EMERGENCY INFORMATION AND CONSENT FORM

Name:		Record No:	Date: / /
Address:		Home PH:	Wk. PH:
City:		SS#:	
State:	Zip Code:	Medicaid No:	
Sex:	D.O.B. : / /	Medicare No:	
Emergency Physician:		Insurance No:	
Attending Physician:		Hospital Pref.:	
Diagnosis:			
Allergies:			
Medications:			
In Case of Emergency Contact or Call:			
Guardian:		Contact # 2:	
Contact # 1:		Contact # 3:	

EMERGENCY CARE, CONSENT AND CONTACTS

In the case of a medical emergency while the client is participating in a program, the staff will provide first aid. In the event that the emergency room, hospitalization, or other appropriate medical or dental care is needed, appropriate transportation to the appropriate facility will be arranged. The parent/guardian/custodian (or designated contact person) will be contacted to meet the client at the facility. If the parent/guardian/custodian (or designated contact person) cannot be reached, the staff member may authorize the physician/dentist/facility to provide emergency treatment.

I, _____ (Client/Legally Responsible Person), authorize Positive Growth Counseling Center to contact the individual and/or physician I have indicated below in the event I become incapacitated due to emergency illness or accident while in treatment. This emergency contact consent will be in lieu of any other authorizations, if any, I have granted, or not granted to the below individual.

I also will hold harmless Positive Growth, Inc. and/or Counseling Center, staff, board of directors and other members against any liability caused by their taking of any emergency procedures and/or contacts. I agree to the Emergency Care Process as outlined above. I will assume the full responsibility of all incurred emergency treatment expenses.

I authorize Positive Growth, Inc. Counseling Center the holder of medical or other information about me to release any information necessary to process insurance claims, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to insurance assignment of benefits apply. I authorize Positive Growth, Inc. to provide, as necessary, to its contracted Qualified Service Organizations (e.g., laboratories, pharmacies, management information systems, billing and collection agencies) the following identifying information: my name, address, telephone number, date of birth, social security number, dates of service, and diagnostic code. This consent is valid until the above transactions related to my services are completed, not to exceed one year from the date below, unless and until I specifically revoke my consent to the release of any or all information at an earlier date.

I have read and understand the information regarding emergency contacts, emergency care and consent and the accounting of disclosure/release of information. All of the aforementioned forms have been explained to me.

I, _____ (Client/Legally Responsible Person) have received a copy of the Clients' Bill of Rights and confidentiality handout and each has been explained to me.

_____	____/____/____	_____	____/____/____
Client/Legally Responsible Person	Date	Employee Signature	Date

CONSENTS FORM

AGREEMENT TO PAY: I agree to pay the established fee of \$_____ per session or the pay plan each month. I understand that:

- I may be denied an appointment and/or sent to Small Claims Court if I refuse to pay when I have the ability to pay.
- It is my responsibility to inform the agency of any changes, which affect the billing or charges to my account.
- I will be charged for a scheduled appointment if not canceled 24 hours in advance.
- We will bill your Insurance Co., CMO or Third Party for services rendered. We ask that you pay your co-pay before each session.
- If my insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement

ASSIGNMENT OF BENEFITS: I authorize payment by my insurance company or Medicare/Medicaid to be paid directly to Positive growth, Inc. Community Based Services for services rendered. I understand that I am financially responsible to Positive growth, Inc. Community Based Services for charges applied to the insurance deductible and for all charges limited by the insurance carrier.

CONSENTS FORM

CONSENT FOR SERVICES: Positive Growth provides services to individuals who have personal, social, emotional, developmental, and substance abuse problems. The staff members are trained to provide appropriate treatment as needed to help the individual. I/we present myself to receive services from Positive Growth, Inc. I/we understand that I have the right and responsibility to participate in all aspects of my plan for care. I/we can withdraw from services at any time. I/we consent to urine drug screens at any time during my treatment. If dissatisfied with decisions regarding my care, I/we can appeal those decisions or file a grievance. Information about me related to my services from Positive Growth, Inc. is confidential and may be privileged. This information is shared with staff involved in my care only on a need to know basis. It cannot be disclosed to a third party without my express consent except under special circumstances that include the following. Information about physical or sexual abuse, exploitation, neglect, or deprivation of a child or incapacitated adult will be reported as required by law. Positive Growth, Inc. will exercise its duty to warn other individuals if I/we threaten physical harm to them; if I/we threaten physical harm to me/other, the Agency will exercise its duty to care and will take reasonable steps to protect me. In the event of a medical emergency jeopardizing my life or health, Positive Growth, Inc. will disclose to my medical emergency care provider the information necessary to permit accurate diagnosis and treatment. When a court of legal jurisdiction issues a proper subpoena or order, the information specified may be submitted to a court of law. Limited information may be provided to law enforcement serving an arrest warrant or investigating a crime. Auditors, reviewers, evaluators, and consultants who are both recognized as legitimate by Positive Growth, Inc.'s Executive Director and are bound to protect confidentiality may obtain information directly related to the execution of their official duties.

I/we agree to treatment as offered by Positive Growth for:

- Myself My Child The person for whom I/we have legal guardian/custodian

In the event I/we cannot bring my minor child or the person for whom I/we am legal guardian/custodian to the Program, then I/we give _____ permission to bring the client to the Program and participate in treatment as needed.

CLIENT RIGHTS AND RESPONSIBILITIES: I have received the client rights handout and the relevant handouts outlining my responsibilities as a client of Positive Growth Community Based Core Services program. I understand that it is my right to ask questions if I need clarification or have concerns.

CONFIDENTIALITY: In accordance with state and federal laws, information maintained about you at this agency will be protected from unauthorized disclosure. No information will be sent to your employer, family members, friends, or anyone else, unless it is discussed with you ahead of time and permission is obtained. Disclosure is permitted under state and federal laws for situations which may be applicable to you such as:

1. In the interest of public safety (life threatening situations)
 2. In response to a court order
- Where state laws require that information be disclosed (e.g., suspected child or adult abuse, Communicable Disease)

Positive Growth Services requires reporting of non-identifying client information. This information is stored in a computerized record system for statistical, program planning, research, evaluation, and funding purposes.

Violation of the Federal and State laws and regulations by a program is a crime. Suspected violations may be reported to the U.S. Attorney in the district where the violation occurs.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary. I further acknowledge that I may revoke, in writing, this consent at any time except to the extent that action based on this consent has been taken.

RELEASE OF INFORMATION FOR PAYMENT: I hereby authorize Positive Growth, Inc. Community Based Services to release the necessary information from my record as requested to _____. This data will include dates of service, types of services, diagnosis, name of person providing services, and the relevant charges. Other information requested may also include any alcohol/drug or HIV/AIDS related treatment. This information will be used to process claims only.

ACKNOWLEDGEMENT OF CHILD ABUSE/NEGLECT REPORTING REQUIREMENT: All health and human service professionals are required by state law to report suspected abuse or neglect to the appropriate authorities. If you have any questions about this, please feel free to ask for a better understanding before you sign. Your signature below acknowledges receipt of this information.

PERMISSION FOR OFF-SITE ACTIVITIES: During the course of treatment, the client may on occasion, be off the premises attending therapeutic group outings. During these times, the client/parent/guardian agrees to release Positive growth, Inc. Counseling Center, Community Based Core Services Program from all liability and responsibility. Transportation will be provided by the program. This consent is valid until separation of client from the program or by written termination of permission by a parent/guardian/self.

Client/Legally Responsible Person

____/____/____
Date

Employee/Witness Signature

____/____/____
Date



AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize _____
(Facility/Provider)

_____ to release
(Address)

Check () all that are applicable to be disclosed:

- | | | |
|--|--|--|
| <input type="checkbox"/> All materials in record | <input type="checkbox"/> Medical history and treatment | <input type="checkbox"/> Psychosocial history |
| <input type="checkbox"/> Financial and Health Insurance | <input type="checkbox"/> Progress notes and Treatment Plan | <input type="checkbox"/> Juvenile Court Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication and treatment records | <input type="checkbox"/> Assessments and diagnosis |
| <input type="checkbox"/> Probation and Legal Information | <input type="checkbox"/> Educational/School Records | <input type="checkbox"/> Continuing Care Plans |
| <input type="checkbox"/> Psycho-Educational Evaluation | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Psychological Evaluation |

from the clinical record of _____ (_____)
(Name of client/recipient of mental health services) (Date of birth)

to **POSITIVE GROWTH, INC. 3660 Market Street, Clarkston, Georgia 30021**

for the purposes of facilitating counseling/consultation, and/or conducting an evaluation. I understand that I may revoke this consent at any time. This authorization is valid until _____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _____ no information released and/or _____
_____.

A copy of this release shall have the same force and effect as the original.

(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.



AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) _____ authorize **POSITIVE GROWTH, INC. 3660
Market Street, Clarkston, Georgia 30021.**

To release and disclose information from the clinical record of:

(Name of client/recipient of mental health services) (Date of birth)

to, and allow such information to be inspected and copied by:

(Facility/Provider)

(Address)

Check () all that are applicable to be disclosed:

- | | | |
|--|--|--|
| <input type="checkbox"/> All materials in record | <input type="checkbox"/> Medical history and treatment | <input type="checkbox"/> Psychosocial history |
| <input type="checkbox"/> Financial and Health Insurance Date | <input type="checkbox"/> Progress notes and Treatment Plan | <input type="checkbox"/> Juvenile Court Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication and treatment records | <input type="checkbox"/> Assessments and diagnosis |
| <input type="checkbox"/> Summary of psychological testing | <input type="checkbox"/> Educational/School Records | <input type="checkbox"/> Only in emergency |
| <input type="checkbox"/> Psycho-Educational Evaluation | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Psychological Evaluation |

I understand that I may revoke this consent at any time. This authorization is valid until _____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _____ no information released and/or _____

A copy of this release shall have the same force and effect as the original.

(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.



School Authorization Release of Information

Consumer's Name: _____ DOB: _____

Legal Guardian's Name: _____

I hereby request and authorize the staff from Positive Growth, Inc. Counseling Center located at 3660 Market Street, Clarkston, GA 30021 (404) 298-9005 to enter my child's school:

School's Name

Address

City and Zip

Phone number

FAX

Additionally, I authorize the releaser or ability to obtain confidential information FROM the school counselor, school social worker, the school principal, school administration, registrar, testing coordinator, special education teachers/coordinator, tutors, and other supportive school staff. The information that may be provided/or obtained to Positive Growth, Inc. can include the following checked items:

- | | |
|---|--|
| <input type="checkbox"/> IEP records | <input type="checkbox"/> Psycho-educational Evaluation |
| <input type="checkbox"/> Attendance records | <input type="checkbox"/> Discipline reports |
| <input type="checkbox"/> Teacher reports | <input type="checkbox"/> Treatments Recommendations |
| <input type="checkbox"/> Grade, Progress Reports, Transcripts | <input type="checkbox"/> Continuing Care Plans |
| <input type="checkbox"/> Attendance of IEP, SST, panel reviews and other pertinent meetings | |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Testing Data | <input type="checkbox"/> Other _____ |

All the information I hereby authorize to be obtained will be withheld in a confidential fashion and WILL NOT be released to another recipient without a written consent by the consumer's legal guardian. The information obtained is for treatment purposes only. This release is protected under the State and Federal Confidentiality Regulations copy is valid in lieu of the original. _____ guardian's initials.

I understand that I authorize the release & obtaining of above checked information. The period necessary to complete all transactions on accounts related to Positive Growth, Inc. services are effective immediately (today's date) _____. This consent will expire twelve months after the date signed. I understand that this does not affect information released prior to this date. This release can be revoked at any time.

Consumer: _____

Date: _____

Guardian's Signature/Date

Witness Signature/Date



ORIENTATION ACKNOWLEDGMENT

I have been furnished a copy of the **POSITIVE GROWTH, INC.** Orientation Packet which explains the mission of **POSITIVE GROWTH, INC.** and the services it offers.

I have been furnished a copy of **POSITIVE GROWTH, INC.** ethical standards and understand that all reported violations of the ethical standards will be investigated.

I have been furnished a Notice of Privacy Practices.

I understand that, with special exceptions, information regarding my treatment is confidential and will be released to other parties only with my written consent. I have been furnished a summary of the rules and procedures Involving confidentiality.

I understand that I, and in some cases my family, will play an active role in setting my goals and planning my services. I understand that a person will be assigned to be responsible for the overall coordination of my services. I will be given the name of this person at the conclusion of the intake process. This person is referred to in the Orientation Packet as my "Service Coordinator".

I understand that I have specific rights as a consumer and that a procedure exists to process any complaints I may have. I have been furnished a list of my rights and the name of the persons I should contact if I have a complaint. I understand that, when necessary, behavior management procedures may be used to prevent injury to myself or others or the destruction of property. I understand I can review these procedures with the person responsible for the overall coordination of my services.

Any fees that I will incur from receiving services at Positive Growth, Inc. and the payment expectations for these fees have been explained to me.

I understand that while I am receiving services, periodic confidential surveys may be conducted by mail, face-to-face, and/or by phone, inquiring as to my satisfaction with services. Also, I understand that after completing services, confidential follow-up may be conducted by mail and/or by phone. I understand that my records may be reviewed by representatives from licensing and accreditation agencies and organizations.

My signature below indicates I understand all of the points listed above and have been furnished a copy of all of the documents referenced.

Consumer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness's Signature: _____ Date: _____



Consumer Rights

1. The right to agree to and approve of your treatment.
2. The right to be involved in planning your treatment.
3. The right to a written Individualized Service Plan (ISP) and be promptly and fully informed of any changes in the plan.
4. The right to have services provided in a way that fits your individual characteristics, needs, and abilities.
5. The right to review and obtain copies of your service record unless the physician or other determines it authorized staff not to be in your best interest.
6. The right to understand how to give permission to release or obtain information about your treatment, as well as how to revoke the permission.
7. The right to be free of physical abuse, sexual abuse, harassment or physical punishment.
8. The right to be treated with respect, dignity and kindness, free of mental abuse, such as humiliation, being threatened or taken advantage of.
9. The right to know funds are used for providing treatment instead of financial gain.
10. The rights to be informed of how to get other help you may need through referral to
 - a) guardians or conservators, b) self-help groups, c) advocacy services, and d) legal services.
11. The right to be provided with information to help you make the best decisions.
12. The right to express who you want for a case manager, therapist, or other service provider.
13. The right to know how to use services when you are in a crisis.
14. The right to be free of any physical restraint or time-out procedure except for the purpose of providing effective treatment and protecting your safety and other persons.
15. The right to have and retain personal property, which does not jeopardize your safety or the safety of other consumers and have such property treated with respect.
16. The rights to written information that explains when the use of treatment interventions and restriction of rights would occur.
17. The right to know the limitations of confidentiality.
18. The right to privacy with respect to your past, present, and future mental health and medical information.
19. The right to receive treatment in the least restrictive environment available.
20. The right to refuse service, unless it is determined by a physician, licensed clinician or licensed psychologist that you are unable to care for self, is dangerous to yourself or others or is mandated by a court.
21. The right to receive clinically appropriate treatment even if it is determined you are unable to pay.
22. The right to be fully informed of the charges for treatment.
23. The right to obtain a copy of the program's most recently completed report of licensing inspections forms.
24. The right to request clarification if you have any questions regarding these rights.
25. The right of referral to legal entities for appropriate representation, and to self-help and advocacy support services.
26. The right to exercise all civil, political, personal, privacy and property rights to which you are entitled to as a citizen.
27. The right to remain free of psychological abuse, including humiliating, threatening, and exploiting actions.
28. The right to file a complaint if you think any of these rights have been restricted or denied. Information on how to file a complaint or contact your Consumer's Rights Representatives is presented on a poster near the reception desk at every service site.

Call or Write to: 404-657-5557. Office of Regulatory Services, ORS, Complaint Intake Unit, 2 Peachtree Street, Atlanta, GA 30303

404-657-7857. The Department of Behavioral Health & Development Disabilities, DBHDD.
2 Peachtree Street, Atlanta, GA 30303

I have reviewed these rights. I have received a copy of these rights and understand that a copy will be placed in my medical record.

Consumer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____