
A MENTAL HEALTH AGENCY
Cross Over
THERAPY, LLC
WE LISTEN, CONVERSE, AND SOLVE.

Orientation Checklist for Persons Served

Purpose

The following information has been provided (i.e. hand-out) as part of the consumer orientation. A check of the item indicates that it has been fully explained and is understood by the consumer.

- ☐ Agency Mission/Philosophy
- ☐ Rights and grievance and appeal procedures
- ☐ Services provided, days and hours of operation, expected level of participation
- ☐ Access to emergency services, after hours
- ☐ Code of Ethics/Conduct
- ☐ Confidentiality policy, limits of confidentiality
- ☐ Methods, opportunities, and policy on input
- ☐ Explanation of financial obligations, fees, and financial arrangements
- ☐ Notification and purpose of participation in the outcome management process
- ☐ Fire, safety, and emergency precautions
- ☐ Policy on restraint (and seclusion if applicable)
- ☐ Policy on tobacco product
- ☐ Policy on illicit or licit drugs brought into the program
- ☐ Identification of the person responsible for service coordination
- ☐ Program rules, including restrictions and the loss and regain of Rights
- ☐ Purpose and process of bio-psychosocial assessment
- ☐ Individual plan development
- ☐ Discharge/transition criteria and procedures

Client Signature: _____ Date: _____

Client Name: _____ Date: _____

Orientation checklist completed by: _____

Client Information Sheet

Thank you for choosing our office! In order to serve you properly, we need the following information. Please Print .

Information will be confidential.

Date:_____ Recipient Name: _____

SSN: _____ Male Female Birth Date:_____ Age: _____

Marital Status: (circle one) Minor Single Married Divorced Separated Widowed

Race/Ethnicity: _____

Home Phone: _____ Cell or Other Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Parish: _____

If Child is Recipient, Parent/Guardian Name: _____

If Child is a Student, Name of School: _____

Person to contact in case of emergency: _____

Phone Number for Emergency Contact: _____

Whom may we thank for referring you? _____

Pharmacy of Choice: _____ Pharmacy Phone Number: _____

Authorization and Release of Information: I certify that I have read and understand the above Information to the best of my knowledge. The above questions have been accurately answered.

Recipient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Date: _____

Authorization To Transport Minor Children

I authorize the staff of Cross Over Therapy, LLC to transport the following minor child(ren), for whom I am the parent or legal guardian:

Name(s) of Child(ren)	Date(s) of Birth
_____	_____
_____	_____
_____	_____
_____	_____

If this authorization is for a single event, please specify the date and destination below:

_____

_____

If nothing is specified, this authorization will remain in effect throughout the time the child remains enrolled in services.

I understand that I may revoke Authorization to transport minor children at any time by withdrawing consent in writing.

_____ _____

Parent or Guardian Signature Date

_____ _____

Cross Over Therapy, LLC Staff Signature Date

Home Safety Questionnaire

1. Do you have any pets? _____

   If no, please skip to question number 5

2. How many pets do you have? _____

3. Are your pets housed indoors/outdoors/or both? _____

4. For safety purposes, are you willing to restrain/secure your pet/s while COT is in the home? {if applicable) _____

5. Are you willing to update your worker (prior to your next scheduled session) if you decide to add any Pet/s to the home? _____

6. Please list any other situations in the home that may present a safety issue?

_____

_____

_____

Recipient/Guardian Signature

_____

COT Signature

School Consent

_____, give Cross Over Therapy, LLC. Permission to provide services
Parent or Guardian

and maintain regular communication with_____
Student's Name

at _____ regarding the behavioral, social, academic and
Name of School

medication orders of my child. These services include but are not limited to the following:

- Community Psychiatric Support and Treatment
- Psycho Social Skills Training
- Individual Counseling
- Medication Monitoring
- Checking in/out for appointments

In addition, I give Cross Over Therapy, LLC. permission to visit and work with _____
Student's Name

in his or her classroom as well as conduct consultations with school staff as needed.

_____ _____
Parent or Guardian Signature Date

_____ _____
Cross Over Therapy, LLC Staff Signature Date

Cross Over Therapy, LLC
Authorization to Use and Disclose Protected Health Information

NOTICE - **PLEASE READ**: I understand that each authorization signed below will remain in effect for 180 days after I sign and date the form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that if I have authorized PCS to disclose my information to person who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to other without my consent or authorization. PCS will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Notice To Recipient Of Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit the recipient of the protected health Information from making 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 CFR, 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 any alcohol or drug abuse client.

Client Name: _____ Date of Birth: _____

Client Address: _____

Social Security Number: _____ Daytime Phone: _____

I hereby authorize the Cross Over Therapy, LLC to:

O Disclose information O Request information 0 Exchange Information

With Name of Person or Entity _____

Address: _____

Telephone / Fax: _____

INFORMATION TO BE USED/DISCLOSED

Initial the following Items needed:

	Diagnostic Assessment/ Intake		Psychological Evaluation Reports		Treatment Plan/ISP
	Progress Notes		Psychiatric Evaluation		Other Social History
	Physician's Orders		Court Reports/Records		Medication Records
	School Records/ Consultation		Laboratory Reports		Employment Records/Reports
	Discharge Summaries		Verbal Reports		Treatment Plan/ISP
	HIV and AIDS Status		Drug and Alcohol Addiction		Other Social History

Other (CLEARLY SPECIFY) _____

Purpose for Disclosure: □ Assist in Treatment Planning □ Continuity of Care

□ Other (Specify) _____

_____

I understand that I may withdraw this consent at any time in the future as explained above and that this consent will expire in 180 days from the dates signed below, unless otherwise specified.

This consent will expire at(Event) _____

when (Condition) _____ OR on _____

whichever occurs first, not to exceed 180 days.

Signature: _____ Relationship: _____ Date:_____

Witness:_____ Date: _____

NOTICE OF REVOCATION

I hereby, revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Client/Guardian Signature: _____ Date Revoked: _____

PCP CONSENT TO RELEASE INFORMATION

WAIVER OF CONFIDENTIALITY FORM

All information that has been gathered on an individual is personal and private, and you are not required to release information. Such information cannot be released without authorized written permission, except as required by law.

I understand that the information in the record of.

Name: (1)	DOB:
Address: (1)	

Is personal and private. HOWEVER, I GIVE MY PERMISSION FOR:

Name: (2)		Phone:
Address: (2)		Fax:
City: (2)	State: (2)	Zip Code: (2)

TO RELEASE TO:

Name: (3)		Phone:
Address: (3)		Fax:
City: (3)	State: (3)	Zip Code: (3)

THE FOLLOWING SPECIFIC **INFORMATION**:

(4) Medical Records, consultation and communication with Primary Care Physician and/or Nurse

I understand that my permission to release may be cancelled at any time except when the information has already been released. My permission to release this information will expire: _____ . I understand that the fax system is not secured (confidential) and therefore release Cross Over Therapy, LLC of any liability for any information becoming available to unauthorized person or persons. I also understand that the inability to secure the fax system is beyond the control of Cross Over Therapy, LLC.

The undersigned certifies that he/ she is the parent/guardian/ representative of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

(6) COTT LOC ,Representative	Date	(7) Client	Date
(8) Parent/Legal Guardian	Date		

Notification Form Regarding Behavior Support and Management Techniques

Cross Over Therapy, LLC is a Mental Health Rehab agency (MHR) that is certified by the Louisiana Department of Health and Hospitals. Based on our certification with the State of Louisiana and to uphold COT's commitment to treat all clients with respect and dignity in a manner that encourages self-control, self-direction, and positive self-esteem, we support the following guidelines regarding behavior management techniques in the agency.

Guidelines:

Toe utilization of manual, mechanical, and chemical restraints is strictly prohibited in any of COT's programming. Moreover, the usage of locked seclusion is not an appropriate mechanism for discipline or to adjust behavior.

In addition to the aforementioned, COT prohibits the following:

- Hitting, spanking, shaking, biting, pinching, or inflicting other forms of corporal punishment
- Restricting a client's movement by binding or tying him or her
- Inflicting mental or emotional punishment, such as humiliating, shaming, or threatening a client
- Depriving a client of meals, snacks, rest, or necessary toilet use
- Confining a client in an enclosed area, such as a closet, locked room, box, or similar cubicle
- Any types of severe physical discipline, inflicted in any manner
- Group discipline for misbehavior of individuals
- Denial of any essential program services
- Denial of visits or communications with family
- Denial of opportunity for at least 8 hours of sleep in a 24-hour period
- Clients in residential facilities shall not be permitted to discipline other residents

Accepted behavior intervention techniques include managing the environment, redirection, time away, de-escalation, directive statements and offering choices.

Your signature affixed to this document represents that a member of COT's personnel has reviewed this policy with you regarding Behavior Management Techniques and its usage through Cross Over Therapy, LLC.

Foster Parent

Biological Parent

Guardian

Client

_____ _____

(Signature) (Date)

_____ _____

(Staff Signature) (Date)

Notice of Privacy Practices Record of Acknowledgements

Name of Client:_____ Date: _____

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make in that notice to you as authorized by law.

Effective Date of this Privacy Notice

The effective date of this privacy notice is: _____

Changes or Revisions to our Privacy Notice

We reserve the right to change our agency's Privacy Notice at any time agree to make the revised or changed notice effective for health information we already have about you as well as any information we receive about you in the future. Should we revise or change our Privacy Notice, we will provide a copy of the notice to you. You may obtain a copy of the new/revised Privacy Notice from the business office or download it from our website (as applicable).

( )Our Privacy notice was revised on _____( )No changes since the effective date listed above. Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of information, Revoking and Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our agency's privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclose concerning our health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our agency' s privacy practices, please contact:

Name of contact person _____ Phone number _____

Address _____

Website Address _____

Acknowledgements

I certify that 1 received a copy of this agency's Privacy and that I have an opportunity to review this document and also questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the agency is committed to protecting my health information.

Date: _____ My signature: _____

Date: _____ My printed name: _____

Signature of Witness

I certify that I am the authorized representative of _____,and that I have received the Privacy Notice on behalf of this individual and that the agency provided me with an opportunity to review this document and ask questions to assist me in Understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the agency is committed to protecting health information.

Date: _____ Signature of Representative: _____

Date: _____ Printed Name: _____ Relationship to Individual: _____

MEDICATION & DIAGNOSIS SCHOOL FORM

To: _____ (Name of School)

Re: _____ (Child Name)

Child's Date of Birth: _____

Diagnosis: _____

Medication(s): _____

The above-named child is in our Homes Community Based Services program where we provide medication assessment, monitoring, and education, individual and family counseling, community psychiatric support and treatment, and psychosocial skills training.

We are committed to cooperating, coordinating, and collaborating with the child's teacher(s) and guidance counselor so that the child's in-school behavior and academic achievement improves. Prepare an Individualized Service/Recovery Plan for the child. We wish to meet at regular intervals (twice per school year or depending on the child's performance) and establish behavior plans and 504 accommodations as necessary. As indicated by their signature below, the parent(s) or guardian(s) are aware and approve of this procedure as a means of helping their child stay in school, avoid suspensions, and gain all they can from the education provided.

Please keep this document in the student's cumulative folder indicating that the school has been notified that the child has a disability related to his or her behavior.

_____

Signature of student's parent(s) or guardian(s)

_____

Signature of COT, LLC staff currently working with the child/youth

_____

Licensed Mental Health Professional Signature

_____

Signature of school personnel indicating knowledge of the above information

Consent to Treatment

► I,_____ give permission for Cross Over Therapy, LLC to give me behavioral
Client name
health treatment. I consent to abide by the Agency's specific policies and procedures relating to services that have been reviewed with me, which include provisions for termination of services at request by me, the physician, or the Agency.

► I allow Cross Over Therapy, LLC to file for insurance benefits to pay for the care I receive. I request the payment of authorized benefits be made to Cross Over Therapy, LLC on my behalf

► I understand that:

Cross Over Therapy, LLC will have to send my medical record information to my insurance company and authorized external review agencies to verify eligibility, confirm benefits, or pay claims. I authorize my records to be reviewed for any necessary audits or accrediting surveys by representatives of CARF and/ or state agencies. I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse, psychiatric/ psychosocial information and AIDS related information. I understand this can be revoked at any time by written request except that disclosure has already occurred in reliance on this consent.

► I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

► I understand that I will receive some or all of the following services:

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Addiction Services
- Individual Counseling
- Family Counseling
- Psychiatric Diagnostic Assessment
- Medication Management

► I acknowledge receipt of Primary Care Solutions Inc.'s handbook, which includes Rights and Responsibilities. The contents have been explained to me and I understand the meaning. I have participated in the care planning process and agree to all of the above.

_____ _____

Licensed Mental Health Professional Signature

Signature of parent(s) or guardian(s)

_____ _____

Signature of COT staff currently working with the child/youth

Signature of school personnel indicating knowledge of the above information

CONSTENT TO MEDICATION

Client's Name: _____

NOTICE TO INDIVIDUAL: PLEASE READ THIS CAREFULLY AND ASK QUESTIONS IF YOU DO NOT UNDERSTAND ANY PART OF IT.

I have been told about and have been given written information about the following recommended medicine(s):

RECOMMENDED MEDICINE(S) AND DOSAGE

I understand that the dosage of the medicine(s) may change based on my condition. The physician has talked with me about the following:

- What medicine(s) I will be taking;
- What the medicine(s) are, intended to do for me;
- Whether the medicine(s) chosen for me requires periodic blood testing;
- The possible side effects, risks, and benefits of the medicine(s);
- Any food-drug interactions which may occur with the medicine(s);

I understand that I have a right to refuse to take medicine(s) and what can happen if I refuse.

CONSENT

o I agree to take the medicine(s) listed above.

o I do not agree to take the medicine(s) listed above.

_____ _____

Medical Psychologist/Psychiatrist Signature Date

_____ _____

Client's Signature Date

_____ _____

Guardian's Signature Date

_____ _____

Guardian's Printed Name Date

SAFETY PLAN - CRISIS PR&VENTION PLAN

Name : _____ Date: _____

PROBLEM BEHAVIORS: These are behaviors I sometimes show, especially when I'm stressed:

□ Losing my temper □ Fighting/Assaulting people □ Feeling suicidal □ Running away □ Using other drugs

□ Injuring myself □ Attempting suicide □ Threatening others □ Using alcohol □ Feeling unsafe

□ Other (please describe):

_____

TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

□ Not being listened to □ Feeling pressured □ Being touched □ Lack of privacy □ People yelling

□ Loud noises □ Feeling lonely □ Arguments □ Not having control □ Being Isolated

□ Darkness □ Being stared at □ Being teased □ Particular time of day: _____ □ Particular time of year: _____

□ Contact with family _____ □ Particular person: _____ □ Other (please describe): _____

WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

□ Sweating □ Breathing hard □ Racing heart □ Clenching teeth □ Clenching fists

□ Red faced □ Wringing hands □ Loud voice □ Sleeping a lot □ Sleeping less

□ Acting hyper □ Swearing □ Bouncing legs □ Rocking □ Can't sit still

□ Being Rude □ Pacing □ Crying □ Squatting □ Damaging things

□ Eating more □ Eating less □ Not taking care of myself □ Isolating/avoiding people □ Laughing loudly/giddy

□ Singing Inappropriately □ Becoming very quiet □ Other (please describe):

_____

INTERVENTIONS: These are things that might help me calm down and keep myself safe when I'm feeling upset: (Check off what you know works; star thing you might like to try In the future)

□ Time out In my room	□ Listening to music	□ Reading a book	□ Sitting with staff	□ Pacing
□ Talking with friends	□ Talking with an adult	□ Coloring	□ Molding clay	□ Humor
□ Exercising	□ A cold cloth on face	□ Writing In a journal	□ Punching a pillow	□ Hugging a stuffed animal
□ Taking a hot shower Lying down	□ Taking a cold shower	□ Playing cards	□ Video Games	□ Lying down
□ Ripping paper	□ Screaming Into pillow	□ Holding Ice in my hand	□ Getting a hug	□ Using the gym
□ Bouncing a ball	□ Male staff support	□ Female staff support	□ Deep breathing	□ Speaking w/ my therapist
□ Drawing	□ Being read a story	□ Making a collage	□ Crying	□ Snapping bubble wrap
□ Being around others	□ Doing chores/jobs	□ Cold water on hands	□ Drinking hot herb tea	□ Using a rocking chair
□ Calling family (who?) _____	□ Other (please describe): _____			