



Park Place Behavioral Health Care

Outpatient Access Center

208 Park Place Blvd. Kissimmee, FL 34741

Phone (407) 846-0023, Ext. 1129 or 3109 or 3114



Instructions for the application for Outpatient Services Children (3 to 17 years old)

Please read the application carefully and complete as much as you can. This information is always confidential and will help us understand your needs. The information requested in this application is to be about the child, except where the parent or guardian is noted.

WE REQUIRE THE FOLLOWING DOCUMENTS.

WITHOUT THESE DOCUMENTS THE APPLICATION WILL NOT BE ACCEPTED.

- A) PARENT OR LEGAL GUARDIAN'S IDENTIFICATION CARD
- B) CHILD'S SOCIAL SECURITY CARD
- C) BIRTH CERTIFICATE –ORIGINAL IS REQUIRED.
- D) CHILD IMMUNIZATION RECORD
- E) INFORMATION OF THE CHILD'S PRIMARY CARE PHYSICIAN (NAME, ADDRESS AND PHONE NUMBER)
- F) INSURANCE CARD.
- G) MEDICAID'S LETTER OF APPLICATION *(If you do not have insurance **and** you are an Osceola County Resident; you must provide the letter from Medicaid showing that you have applied for benefits. You will then be eligible for our financial assistance program for Medications and Counseling.) Please request a financial assessment application from the reception.*

WE ACCEPT APPLICATIONS MONDAY THROUGH FRIDAY 8:00 AM TO 3:00 PM

IT IS NOT NECESSARY FOR THE CHILD TO BE PRESENT FOR THE ORIENTATION APPOINTMENT



**INFORMED CONSENT CONCERNING
AGENCY POLICIES**

All applications for services provided by PPBHC are made with the following mutual understandings. Please initial each paragraph to indicate your understanding and acceptance.

1. CONFIDENTIALITY – OTHER CLIENTS

CLIENT INITIALS: _____

As a client of Park Place Behavioral Health Care (PPBHC) I understand that under the rules of confidentiality, information disclosed in individual or group therapy sessions is confidential in nature. I agree to keep confidential all information that I hear or see in regard to other clients of PPBHC. I agree not to discuss any information concerning other clients of PPBHC with anyone other than PPBHC clinical staff.

2. CLIENT CONFIDENTIALITY – GENERAL

CLIENT INITIALS: _____

All information and records concerning clients that are maintained at PPBHC are considered confidential. This means that information about you will not be released to others by PPBHC unless you give us a separate, written permission for the release of information **EXCEPT:**

- In cases of suspected abuse or neglect that involve children, disabled adults or the elderly.
- In cases of infectious diseases that require mandatory reporting.
- In cases when a client is considered a danger to themselves or others as defined under Florida Statutes.
- In cases when there is a legitimate court order.
- As per the terms listed in sections 3, 4 & 5 below.

3. CONFIDENTIALITY: INFORMED CONSENT ABOUT FLORIDA ADM & THIRD PARTY PAYORS

CLIENT INITIALS: _____

As a Community Mental Health Center, PPBHC is required to open your clinical record(s) and collect additional personal and clinical information about you that is sent to the State of Florida Department of Children and Families ADM Office(s) and the Florida Mental Health Institute (FMHI). Additionally, most third party payors (for example insurance companies, Medicaid, Medicare, your HMO, etc.) require that PPBHC release clinical information about you to them to be paid for services rendered. Releases of information to third party payors may be avoided by paying your full treatment fees in cash; however, releases to Florida ADM and FMHI may still occur.

4. CONFIDENTIALITY: INFORMED CONSENT FOR CONSUMER SATISFACTION & FOLLOW-UP SURVEYS

CLIENT INITIALS: _____

PPBHC strives to provide the highest quality of services to our clients. In an effort to monitor the effectiveness of our services we and others associated with us will conduct satisfaction surveys and treatment effectiveness surveys both during the course of your treatment and after you have been discharged. You may decline to participate whenever you are contacted.

5. CONFIDENTIALITY: INFORMED CONSENT FOR TREATMENT TEAM SHARING OF INFORMATION

CLIENT INITIALS: _____

Most facilities operated by PPBHC operate under a treatment team form of therapeutic intervention. Members of the treatment team may include such diverse professionals as: psychiatrists, psychologists, nurses, therapists, social workers, treatment coordinators, case managers, screeners, mental health/substance abuse tech's, residential advisors, day program therapists, and the supervisors of these persons. Treatment team members may share confidential information, such as information that was discussed in a therapy session. However, the members of the treatment team are all bound by the rules of confidentiality (See above, Confidentiality – General #1.).



6. AUTHORIZATION & ASSIGNMENT OF BENEFITS

CLIENT INITIALS: _____

I authorize PPBHC to release information as necessary to ensure payment of claims submitted to my insurer and/or others who may provide payment for my treatment(s). I further irrevocably assign to PPBHC my interest in all insurance or other benefits which are paid for services rendered on my behalf.

7. AGREEMENT OF FINANCIAL RESPONSIBILITY

CLIENT INITIALS: _____

I understand that payment for services rendered, including any insurance co-payment, is due when services are delivered. I understand that unless another party approved by PPBHC guarantees to pay my bill, I am personally responsible for it. If collection under this agreement is enforced by legal proceedings or through an attorney at-law, I agree to pay all collection costs and expenses and reasonable attorney's fees. This agreement includes expenses and reasonable attorney fees on appeal. This agreement is governed by the laws of the State of Florida. My rights under this agreement are not subject to assignment.

8. REQUEST FOR REDUCED FEES

CLIENT INITIALS: _____

PPBHC is a private, not-for-profit community mental health/substance abuse treatment center. Consumers who receive services not covered by insurance are responsible for our full fees. However, we do offer an option to qualify for reduced fees based on your income. *If you have no insurance benefits and wish to apply for reduced fees, please request a financial information packet.*

9. CERTIFICATION OF TRUTHFULNESS

CLIENT INITIALS: _____

I hereby certify that all information provided to PPBHC is true to the best of my knowledge and belief. I understand that in accordance with Florida Statutes Section 817.50 providing false information to defraud a healthcare provider for the purpose of obtaining goods and services is a second degree misdemeanor.

10. AUTHORIZATION & CONSENT FOR ADULT TREATMENT

CLIENT INITIALS: _____

I acknowledge that I am applying for mental health/substance abuse treatment services. I authorize PPBHC to administer such psychological, psychiatric, and/or other mental health/substance abuse, medical and behavioral procedures that are considered necessary for my treatment. I understand that all medications have some known side-effects and I will discuss any side-effects with my psychiatrist. I understand that no guarantee or assurance has been made as to the results that may be obtained from treatment.

11. AUTHORIZATION & CONSENT FOR MINOR TREATMENT

LEGAL GUARDIAN SIGNATURE: _____

I, the legal guardian of this minor, do hereby attest that I can legally make decisions regarding their care. I further acknowledge that I am applying for mental health/substance abuse treatment services for them. I authorize Park Place Behavioral Health Care to administer such psychological, psychiatric, and/or other mental health medical and behavioral procedures that are considered necessary for their treatment. I understand that all medications have some known side-effects and I will discuss any side-effects with the prescriber. I understand that no guarantee or assurance has been made as to the results that may be obtained from treatment.



CLIENT APPLICATION FOR SERVICES

Do not complete this Application for Services if you do not agree to all of the agency policies, terms and conditions.

Please complete all information as it applies to the applicant.

Date: _____ - _____ - _____

Name: _____ LAST NAME FIRST MIDDLE INITIAL MAIDEN NAME

Date of Birth: _____ - _____ - _____ SSN: _____ - _____ - _____

Country of Birth: _____ Age: _____ Gender: M F

Ethnicity Puerto Rican Mexican Cuban Other Hispanic Haitian None of these

Race: White Black Hispanic American Indian Nat.Hawian/Pacific Islander Asian Alaskan Other

Current Address: _____ STREET ADDRESS CITY STATE ZIP CODE

Permanent Address: _____ STREET ADDRESS CITY STATE ZIP CODE (If different than Current Address)

Home Telephone: (____) _____ Work: (____) _____ Other: (____) _____

Who referred you to us? _____ NAME ADDRESS CITY, STATE & ZIP TELEPHONE

Marital Status 1. SINGLE FEMALE NEVER MARRIED 3. SEPARATED 5. WIDOWED 7. MARRIED NO CHILDREN 2. MARRIED W/CHILDREN 4. DIVORCED 6. COHABITATION 8. SINGLE MALE NEVER MARRIED

Are you a United States Veteran? Yes No

Employment Status 01. Full Time 04. On Lay-off 07. Self Employed 11. Disabled 02. Part-time 05. Looking for a job 08. Child - Not Employed 12. Retired 03. Sheltered Workshop 06. Not Employed 09. Student-collage

Religious Preference 1. Protestant 3. Jewish 8.None/ Unknown 2. Catholic 4. Latter Day Saints Other _____

What is the highest grade level you have completed in school? _____

Did you take, or are you currently enrolled in any Special Education classes? Yes No



Park Place Behavioral Health Care

PLACE LABEL HERE

Source of Support
{circle all that apply}

- 1. Job/ Employment
- 2. Sup Security Income, Retirement, Pension
- 3. Parents
- 4. Friends
- 5. SS Disability
- 6. W.A.G.E.S./T.A.N.F.
- 7. Unknown
- 8. None
- 9. Other _____

Are you currently involved with the legal system? Yes No **If yes, explain:** _____

Living Arrangement

- 1. Own / Rent
- 2. Foster Home
- 3. Group Home / ALF
- 4. Retirement Facility
- 5. State Hospital
- 6. Live With Parents/ Relatives
- 7. Juvenile Facility
- 8. None/ Homeless

FINANCIAL INFORMATION OF RESPONSIBLE PARTY:

How may dependents do you have? _____ **How many dependents live in your house?** _____

In the boxes below put the number of people by age group living with you in your house.

Age Group	0 to 5 years	6-12 years	13-18 years	18+	Total # in House
How Many?					

Current Or Most Recent Employer:

COMPANY NAME ADDRESS CITY, STATE & ZIP TELEPHONE DATES WORKED

Who do you want us to contact in case of an emergency involving the applicant?

NAME RELATIONSHIP ADDRESS CITY, STATE & ZIP TELEPHONE

If applicant for services is under 18: Parent or guardian's SSN: _____ - _____ - _____

PARENT/ GUARDIAN'S NAME RELATIONSHIP ADDRESS CITY, STATE & ZIP TELEPHONE

Household Income: \$ _____ **per** {Circle} *week 2 weeks month year*

Insurance Information: {Such as Medicare, Medicaid, an HMO, etc.}
If you have your insurance card(s) with you, please give them to the receptionist to copy

Card Attached _____
POLICY HOLDER'S NAME INSURANCE COMPANY GROUP# POLICY# TELEPHONE

Card Attached _____
POLICY HOLDER'S NAME INSURANCE COMPANY GROUP# POLICY# TELEPHONE



Park Place Behavioral Health Care

Place Label Here

APPLICATION FOR SERVICES Medical Information and History

Applicant Name: _____
LAST NAME FIRST

Date: _____ - _____ - _____

The name(s) and the relationship(s) to the applicant of any person(s) completing or assisting in the completion of this form if other than the applicant: _____

➤ Who is your regular Family Physician?

PHYSICIAN NAME ADDRESS CITY, STATE & ZIP TELEPHONE

➤ When was you last physical examination? Month: _____ Year _____

➤ Are you currently seeing a medical doctor or a Chiropractic Physician for treatment of any problem? Yes No

If yes, please explain: _____

➤ Are you presently taking any medications including over-the counter drugs? Yes No

➤ If yes, please list: _____

➤ Do you have any allergies to foods? Yes No Do you have any allergies to drugs? Yes No

If yes, please explain: _____

➤ If applicant is a minor child, are his/ her vaccinations (shots) up to date? Yes No

➤ If no, please explain: _____

➤ Have you had any major illnesses, injuries or operations in the past 5 years? Yes No

➤ If yes, please explain: _____

➤ Number of Cigarettes per day _____ Amount of alcohol per day _____

➤ Please check any of the following conditions that may apply or have applied to you

<input type="checkbox"/> Abdominal Hernia	<input type="checkbox"/> Accident Prone	<input type="checkbox"/> Agitation	<input type="checkbox"/> Alcohol or Drug Use	<input type="checkbox"/> Allergies
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Blackouts
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ears Ringing	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Foot Numbness
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Gas pains	<input type="checkbox"/> Hand Numbness	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Herniated Disc
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Lack Concentration	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Nausea	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Pain
<input type="checkbox"/> Pregnant	<input type="checkbox"/> PMS	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sleep Changes	<input type="checkbox"/> Weight Changes
<input type="checkbox"/> Other Symptoms: _____				

Park Place Behavioral Health Care
CHILD SYMPTOM CHECKLIST

NAME: _____ **ID:** _____ **DATE:** _____ **AGE:** _____

GUARDIAN: _____ **PERSON COMPLETING FORM:** _____

WHAT BROUGHT YOU TO PPBHC? _____

WHAT KIND OF HELP DO YOU THINK YOU NEED? _____

WHO REFERRED YOU? _____

SYMPTOM CHECKLIST Please check the symptoms your child is currently experiencing:

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Pretending to be sick | <input type="checkbox"/> Rocking | <input type="checkbox"/> Stammering |
| <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Stuttering |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Soiling | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Rituals |
| <input type="checkbox"/> Physical complaints | <input type="checkbox"/> Masturbation | <input type="checkbox"/> Head banging | <input type="checkbox"/> Obsessive |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hair pulling | <input type="checkbox"/> Tics | <input type="checkbox"/> Other: _____ |

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Clinging | <input type="checkbox"/> Demanding | <input type="checkbox"/> Shy | <input type="checkbox"/> Dislikes mother |
| <input type="checkbox"/> Jealous | <input type="checkbox"/> Bossy | <input type="checkbox"/> Ignores others | <input type="checkbox"/> Dislikes father |
| <input type="checkbox"/> Teased by others | <input type="checkbox"/> Feels unwanted | <input type="checkbox"/> Isolates self | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Difficulty making & keeping friends | <input type="checkbox"/> Feels unpopular | <input type="checkbox"/> Other interpersonal problems _____ | |

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Whining | <input type="checkbox"/> Anxious/tense | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Depressed | <input type="checkbox"/> Fearful/worried | <input type="checkbox"/> Thoughts of hurting self |
| <input type="checkbox"/> Feels hopeless | <input type="checkbox"/> Feels overwhelmed | <input type="checkbox"/> Feels guilty | <input type="checkbox"/> Suicide gesture |
| <input type="checkbox"/> Forgets things | <input type="checkbox"/> Appears preoccupied | <input type="checkbox"/> Angry | <input type="checkbox"/> Suicide threat |
| <input type="checkbox"/> No joy in life | <input type="checkbox"/> Low energy | <input type="checkbox"/> Loses temper | <input type="checkbox"/> Suicide attempt |

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Plans to hurt someone | <input type="checkbox"/> Fights | <input type="checkbox"/> Steals | <input type="checkbox"/> Oppositional |
| <input type="checkbox"/> Mistreats children | <input type="checkbox"/> Lies | <input type="checkbox"/> Curses | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Disrespects authority | <input type="checkbox"/> Rebellious | <input type="checkbox"/> Lacks initiative | <input type="checkbox"/> Accident prone |
| <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Manipulative | <input type="checkbox"/> Lazy | <input type="checkbox"/> Irresponsible |
| <input type="checkbox"/> Demands attention | <input type="checkbox"/> Vandalism | <input type="checkbox"/> Changes in friends | <input type="checkbox"/> Blames others |
| <input type="checkbox"/> Trouble with law | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Fights about bedtime | <input type="checkbox"/> Use of Rx /overcounter meds. |
| <input type="checkbox"/> Sense of right & wrong | <input type="checkbox"/> Change in dress | <input type="checkbox"/> Defiant | <input type="checkbox"/> Use of illegal substance |
| <input type="checkbox"/> Cheats | <input type="checkbox"/> Runs away | <input type="checkbox"/> Overactive | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Argues | <input type="checkbox"/> Rages | <input type="checkbox"/> Use of tobacco |
| | | | <input type="checkbox"/> Use of caffeine |

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Classroom behavior problems | <input type="checkbox"/> Short attention span | <input type="checkbox"/> Under achievement | <input type="checkbox"/> Boredom |
| <input type="checkbox"/> Difficulty following directions | <input type="checkbox"/> Suspensions | <input type="checkbox"/> Skipping school | <input type="checkbox"/> Reading problem |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Problems studying | <input type="checkbox"/> Difficulty sitting still | <input type="checkbox"/> Over talkative |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Conflict with teacher | <input type="checkbox"/> Trouble finishing projects | |
| <input type="checkbox"/> Frequent absences | <input type="checkbox"/> Bullying | <input type="checkbox"/> Afraid of school | <input type="checkbox"/> Overachiever |
| <input type="checkbox"/> Drastic change in grades | <input type="checkbox"/> Gets teased a lot | <input type="checkbox"/> Nervous about school work | |
| <input type="checkbox"/> Worries about perfect performance | | <input type="checkbox"/> Difficulty keeping hands to self | |
| <input type="checkbox"/> Physical problems interfere with school work | | <input type="checkbox"/> Failing in school | <input type="checkbox"/> Learning problem |
| <input type="checkbox"/> Uses illness to get out of doing school work or attending school | | <input type="checkbox"/> No interest in school | |

- | | |
|--|--|
| <input type="checkbox"/> Feels others are out to get him/her | <input type="checkbox"/> Eating non-food material |
| <input type="checkbox"/> Feels different from everyone else | <input type="checkbox"/> Hears voices others don't |
| <input type="checkbox"/> Feels things are unreal | <input type="checkbox"/> Suspicion of others |
| <input type="checkbox"/> Other unusual behavior: _____ | |

Any other behaviors that your child may be experiencing (the reason for seeking help): _____

Previous mental health services: _____

Park Place Behavioral Health Care

CHILD / ADOLESCENT EVALUATION ADDENDUM

NAME: _____ DOB: _____ AGE: _____

INFORMANT: _____ RELATIONSHIP TO CHILD: _____

REFERRED BY: _____

ANY LEGAL/SOCIAL AGENCY INVOLMENT: _____ YES _____ NO

Name of Agency: _____

PARENTS MARITAL HISTORY:

	MOTHER	FATHER
Number of marriages	_____	_____
Children from previous marriages	_____	_____
Date of most recent marriage	_____	_____
Date(s) of separation (s)	_____	_____

IF DIVORCED:

How Long: _____

Custody arrangements: _____

Visitation Schedule: _____

Child's adjustment to divorce: _____

Other household in which child has resided: _____

CHILD'S MEDICAL HISTORY

Mother's Pregnancy

Illnesses or Complications: _____

Medications Taken: _____

Tobacco/Alcohol /Other Drugs (prescription or otherwise): _____

Length of pregnancy (months): _____

Delivery (type: e.g. head first, breech): _____

Birth Weight: _____ APGAR Rating (if known): _____

Problems during delivery or shortly there after: _____

Medication/Anesthesia during delivery: _____

Length of stay in hospital: _____

EDUCATIONAL HISTORY

Current School _____ Grade: _____

Number of school attended in the last 60 days: _____

Teacher(s): _____

Guidance counselor: _____

Special Classes/Track/Level: _____

Teacher's Comments: _____

Current and/or past academic/behavioral problems in school (specify, including interventions tried and results):

SOCIAL HISTORY

Does child have an adequate number of friends? Describe the quality of the friendships. Include age of friends, best friend, ability to make friends, and to maintain relationships:

Clubs/Groups: _____

Hobbies/Talents: _____

Pets: _____

Religious Activities: _____

Responsibilities/Chores in household: _____

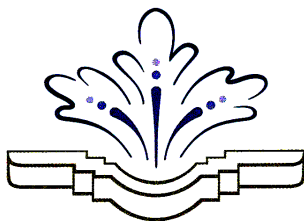
USUAL DISCIPLINARY TECHNIQUES OF PARENT

Describe the methods used to discipline you child(ren): _____

Any differences with this child compared to your other children: _____

Describe how mother and father were disciplined as children: _____

PLEASE COMMENT ON ANY AREAS OF CONCERN NOT COVERED ABOVE: _____



**Park Place Behavioral Health Care
Health Questionnaire for Tuberculosis Exposure**

Name _____ Date _____

This questionnaire is a screening tool to help identify possible tuberculosis infection in our clients and employees. Please check "yes" or "no" to ALL symptoms that apply to you.

- | | | |
|---|-----|----|
| 1. Do you have productive cough lasting 3 or more week? | YES | NO |
| a. If so, what color is the sputum? _____ | | |
| 2. Have you been losing weight without dieting or other known reasons? | YES | NO |
| 3. Do you have a persistent low-grade fever? | YES | NO |
| 4. Do you have night sweats- waking up with sheets drenched? | YES | NO |
| 5. Have you ever had close contact with someone with or suspected of having TB? | YES | NO |
| 6. Have you ever been told you had a positive TB test? | YES | NO |
| a. If YES, did you have a Chest X-ray? | | |
| i. When Month/Year: _____ | | |
| ii. Where: _____ | | |
| iii. Outcome: _____ | | |
| iv. Type of treatment prescribed: _____ | | |

For official use only

** If the client and employee answers "yes" to three (3) or more of these questions the Safety/Infection Control committee requests that the admitting physician or Infection Control nurse be notified and a PPD administered. If this is an outpatient, they should be referred to the Health Department and results of a PPD obtained before seeing the client in the clinic.

Reviewed by: _____ Date: _____

Action Taken:

1. **PPD administered:** YES NO Date: _____ Time: _____
Lot: _____ Exp date: _____

Signature of Nurse Performing Test: _____

48 hours Reading: Date: _____ Time: _____ Induration: _____

Signature of Nurse Reading Test: _____

72 hours Reading: Date: _____ Time: _____ Induration: _____

Signature of Nurse Reading Test: _____

2. **Sent for chest x-ray:** Date: _____ Where: _____
Results Obtained: _____ Date: _____

3. Physician Notified: YES NO Infection Control Nurse Notified: YES NO



Park Place Behavioral Healthcare

◇ “**MANAGEMENT AND PROTECTION OF PERSONAL HEALTH INFORMATION POLICY**”

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review this carefully.

I. Our Duties As They Relate to Your Protected Health Information (PHI)

- A. Our records about you contain health information that is very personal. The confidentiality of this personal information is protected by federal and state law. We have a duty to safeguard your Protected Health Information (PHI) which includes individually identifiable information about:
 - 1. Your past, present, or future health or condition,
 - 2. Provision of health care to you
 - 3. Payment for the health care considered PHI
- B. We are required to:
 - 1. Safeguard the privacy of your PHI,
 - 2. Give you this Notice which describes our privacy practices,
 - 3. Explain how, when, and why we may use or disclose your PHI
- C. Except in very specific circumstances, we must use or disclose only the minimum PHI that is necessary to accomplish the reason for the use or disclosure.
- D. We must follow the privacy practices described in the Notice; however, we reserve the right to change the terms of this Notice at any time and to make the new Notice provisions effective for all protected health information that we receive, disclose, or maintain. Should our Notice change, we will post a new Notice. You may request a copy of the new notice from your therapist and from our website at www.ppbh.org.

II. Why We May Need to Use or Disclose Your PHI:

- A. We use or disclose PHI for a variety of reasons. For some of these uses or disclosures we must have your written authorization. For some, the law permits us to make some uses or disclosures without your authorization.

B. Generally these uses or disclosures are related to treatment, payment, or health care operations. Some examples of these uses or disclosures are:

1. For treatment:

a. We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team.

2. To Obtain Payment:

a. We may use or disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicaid to get paid for services that we have given or provided for you.

3. For Health Care Operations:

a. We may use or disclose your PHI in the course of operating our community mental health center. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.

4. To Remind You of Appointments:

a. Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

III. Uses and Disclosures For Which We Require Your Authorization (consent):

A. When the use of disclosure goes beyond treatment, payment, or health care operations, we are required to have your written authorization. There are some exceptions to this rule, and they are listed below.

B. Authorizations can be revoked by you at any time to stop future uses or disclosures, except where we have already used or disclosed your PHI in reliance upon your authorization.

IV. Uses and Disclosures For Which We Do Not Require Your Authorization:

A. The law permits us to use or disclose your PHI *without written authorization* in the following circumstances:

1. When a Law Requires Disclosure

a. We may disclose PHI when a law requires that we report information about suspected abuse, neglect, or domestic violence, or in response to a court order, or to a law enforcement official. We must also disclose PHI to authorities who monitor our compliance with these privacy requirements.

2. For Public Health Activities
 - a. We may disclose PHI when we are required to collect information about diseases or injuries, or to report vital statistics to a public health authority.
3. For Health Oversight Activities
 - a. We may disclose PHI for health oversight activities such as audits, inspections, civil or criminal investigations or actions.
4. Relating to Decedents
 - a. We may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors.
5. For Organ, Eye, or Tissue Donations Purposes
 - a. We may disclose PHI to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
6. For Research Purposes
 - a. In certain circumstances, and under supervision of a privacy board or institutional review board, we may disclose PHI for research purposes.
7. To Avert Threat to Health or Safety
 - a. In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
8. For Specialized Government Functions
 - a. We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and from national security reasons, such as protection of the President.
9. For Workers' Compensation
 - a. We may disclose PHI to comply with workers' compensation laws.

V. Uses or Disclosures For Which You Must Be Given An Opportunity To Object

- A. Sometimes we may disclose your PHI if we have told you that we are going to use or disclose your information and you did not object. Some examples are:
 1. Patient directories
 - a. Your name, location, general condition, and religious affiliation may be put into our patient directory for use by clergy and callers or visitors who ask for you by name.
 2. To family, friends, or others involved in your care
 - a. We may share with these people information directly related to your family's, friend's, or other person's involvement in your care, or payment for your care. We may also share you PHI with these people to notify them about your location, general condition, or death.

- B. If there is an emergency situation and we do not have time to allow you to object to the disclosure, we may still disclose your PHI if you have previously given your permission and disclosure is determined to be in your best interests. If we do this, you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

VI. Your Rights As They Relate to Your Protected Health Information (PHI)

A. You have the following rights relating to your PHI:

1. To request restrictions on uses or disclosures
 - a. You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use or disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses or disclosures that are required by law.
2. To choose how we contact you
 - a. You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
3. To inspect and copy your PHI
 - a. Unless your access is restricted for clear and documented reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days for PHI we keep on-site. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed.
4. To request amendment of your PHI
 - a. If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is:
 - i. Correct and complete,
 - ii. Not created by us or not part of our records; or,
 - iii. Not permitted to be disclosed.
 - b. A denial will state the reasons for denial. It will also explain your rights to have your request, our denial, and any statement in response that you provide, added to your PHI.
 - c. If we approve the request for amendment, we will change the PHI and inform you, as well as tell others who need to know about the change in the PHI.

5. To find out what disclosures have been made
 - a. You have the right to get a list of when, to whom, for what purpose, and what content of your PHI has been released, except for instances of disclosure that were made for treatment, for payment, for health care operations, to you, per a written authorization, for national security or intelligence purposes, to correctional institutions or law enforcement officials, or for the facility directory. The list also will not include any disclosures made before April 14, 2003.
 - b. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
6. To receive a copy of this notice
 - a. You have a right to receive a paper copy of this Notice or an electronic copy by email upon request.

VII. How to Complain About Privacy Practices

- A. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VIII below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the following address: United States Department of Health and Human Services (HHS), Attention: Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, Georgia 32303-8909. We will take no retaliatory action against you if you make such complaints.

VIII. Contact Person for Additional Information, or to Submit a Complaint

- A. If you have questions about this Notice, need additional information, or have any complaints about our privacy practices, please contact: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 6, Room 124, Tallahassee, Florida 32399-0700, (850) 487-1901.

IX. Effective Date

- A. This Notice is effective on February 1, 2003.



Park Place Behavioral Healthcare

*** ACKNOWLEDGEMENT FORM**

HIPAA

Health Insurance Portability and Accountability Act

**“MANAGEMENT AND PROTECTION OF
PROTECTED HEALTH INFORMATION POLICY”**

THIS FORM IS TO ACKNOWLEDGE THAT A COPY OF THE “MANAGEMENT AND PROTECTION OF PROTECTED HEALTH INFORMATION POLICY” HAS BEEN PROVIDED TO ME ON THE DATE INDICATED BELOW.

PATIENT SIGNATURE

DATE

PATIENT NAME

◇ Page 1-5 information goes to the “Person Served”.

* Page 6, signed original, goes in medical record chart.

PARK PLACE BEHAVIORAL HEALTH CARE, INC.
STATEMENT OF RIGHTS

I. Right to Individual Dignity

You have the RIGHT to:

1. Be treated with respect at all times.
2. Be free from abuse and neglect.
3. Be free from exploitation, retaliation and humiliation.
4. Have freedom of movement, unless it has been restricted as a part of your treatment or by a judge.
5. Have freedom religion and practice.

II. Right to Treatment

You have the RIGHT to:

1. Appropriate treatment, regardless of your ability to pay.
2. Receive treatment in the least restrictive setting.

III. Right to Express and Informed Consent

You have the RIGHT to:

1. Consent or not to consent to treatment, unless restricted by a judge or in an emergency. If you are under 18 years of age, your guardian must also be asked to give express or informed consent for you.
2. Be informed about:
 - The reason for your admission.
 - Your proposed treatment.
 - Any potential side effects of any treatment.
 - Your approximate length of stay.
 - Other possible treatments.
3. Take back any consent to treatment, either verbally or in writing, by you, your guardian or guardian advocate.
4. If necessary, to be provided, through the court, a guardian advocate to make decisions regarding your treatment.

IV. Right to Quality Treatment

You have the RIGHT to:

1. Receive services that are skillfully, safely and humanely administered.
2. Receive appropriate medical, vocational, social, educational and rehabilitative services.

V. Right to Communication, Abuse Reporting and Visits

You have the RIGHT to:

1. Have visitors at reasonable hours, unless visits are restricted as part of your treatment.
2. Send and receive mail and use the telephone, unless restricted as part of your treatment.
3. Have access to a private telephone to report any possible abuse or neglect to the Florida Abuse Hotline at 1-800-962-2873.

VI. Right to Care & Custody of Personal Effects

You have the RIGHT to:

1. Have your personal clothing and belongings, unless restricted as part of your treatment.
2. Have a written inventory of any of your personal clothing or belongings that are taking from you.

VII. Right to Vote in Public Elections

You have the RIGHT to:

1. To vote in all public elections, if eligible.
2. Be assisted in registering to vote and voting
3. To know there is a procedure for you to obtain a voter registration form and application for absentee ballots.

VIII. Right to Ask for a Court Order (A Writ of Habeas Corpus)

You have the RIGHT to:

1. Question the cause and legality of your being detained.
2. To ask the circuit court to order your release.

IX. Right to Clinical Records

You have the RIGHT to:

1. Have reasonable access to your own records.
2. Authorize release of information to people or agencies.
3. Have your records kept confidential.

X. Right to Education for Children

You have the RIGHT to:

1. Receive education as appropriate and in the least restrictive setting possible in accordance with Chapter 232.01(1)(e), Florida Statutes.

XI. Right to Designate Representatives

You have the RIGHT to:

1. Designate a person to receive any required notices.

XII. Right to Participate in Treatment & Discharge Planning

You have the RIGHT to:

1. Help make decisions about your treatment and provide written comments on your treatment plan.
2. Informed consent or refusal or expression of choice regarding the composition of the service delivery team.
3. Help make plans for your discharge.

