



**Client Name: (Please Print)** \_\_\_\_\_

**Date:** \_\_\_\_\_

**TYPE OF INTAKE**

**Thank you for choosing The Transition House Inc. to provide you with services, please read over the following documents carefully and if you have any questions please inform staff and we will clarify or answer any questions that you may have.**

**What is the reason for you coming here today?**

- Mental Health Evaluation**
- Substance Abuse Evaluation**
- Psychiatric Evaluation**
- Psychological Evaluation**
- Individual Counseling**
- Couples counseling**
- Family Counseling**
- Group Counseling**
- Psychoeducational Classes**
- Other please specify:** \_\_\_\_\_

HEALTH SCREENING - OUTPATIENT

<b>Information supplied by:</b> <input type="checkbox"/> INDIVIDUAL				<b>DATE:</b>	
<input type="checkbox"/> OTHER (specify name and relationship):					
NAME (Last, First MI)				<b>BIRTHDATE:</b>	
RECENT IMMUNIZATION? (Tetanus, Flu, Pneumonia)					
DO YOU HAVE ANY ALLERGIES?      NO      YES (If YES, to what & explain reaction below):					
<input type="checkbox"/> <input type="checkbox"/>					
<b>FEMALES ONLY:</b>		Date of last Menstrual Period	Menopause	Post Menopause	
<b>DO YOU HAVE ANY OF THE FOLLOWING? Please circle No or Yes</b>					
Unsteady Walks or falls	NO	YES	Lung Problems	NO	YES
Ringin in the ears	NO	YES	Swallowing Problems	NO	YES
Fractures/Dislocations	NO	YES	Nausea / Vomiting	NO	YES
Arthritis/Back/Neck Problems	NO	YES	Weight gain/loss last 6 months	NO	YES
Heart Problems/Chest Pains	NO	YES	Diabetes	NO	YES
Heart Murmur	NO	YES	Thyroid Problems	NO	YES
Ankle/Leg Swelling	NO	YES	Gastrointestinal Problems	NO	YES
Blood Pressure Problems (H/L)	NO	YES	Ulcer / Rectal Bleeding	NO	YES
Peripheral Vascular Disease	NO	YES	Kidney / Urinary Problems	NO	YES
Difficulty Breathing / Asthma	NO	YES	Stroke/Seizure/Severe Headache	NO	YES
Chronic Bronchitis/Emphysema	NO	YES	Dizziness/Blackouts/Fainting	NO	YES
					Mental Illness      NO      YES
					Hepatitis/Jaundice      NO      YES
					Mononucleosis      NO      YES
					Tuberculosis      NO      YES
					Sexually Transmitted Disease      NO      YES
					Cancer      NO      YES
					Cold/Sore Throat/Sinusitis      NO      YES
					Bleeding Disorders / Anemia      NO      YES
					HIV / AIDS      NO      YES
					Other: _____
<b>EXPLAIN ANY YES ANSWER:</b>					
<b>LIST ALL SIGNIFICANT MEDICAL PROBLEMS</b> No Medical problems					
Date Defined	Medical Problem	Duration	Under Physician Care	Physician	Meds Prescribed

<b>NAME OF PRIMARY CARE PHYSICIAN:</b>	<b>DATE OF LAST PHYSICAL:</b>
May we contact your doctor to request further information about your medical condition?      YES      NO	
Do you need a referral for a Primary Care Physician?      YES      NO	

**If you have not seen a Primary Care physician in the last 12 months we strongly suggest you make an appointment, if you do not have a PCP your Primary Counselor will assist you with a local PCP referral.**

I am aware that maintaining my health is important, especially when taking medications. As such I am aware of the necessity to schedule yearly physical and eye exams. It is also important to get routine lab work (CBC, Chemistry Profile, and Urinalysis); EEG (electrocardiogram), and Thyroid Profile whenever it is recommended. If I am on medication I will be asked to get lab tests done to test my medication level, for example, Lithium Level. I understand it is my responsibility to follow through with the above recommendations.



*The Transition House has the right to change the way information is shared and to make changes for all protected health information it keeps. Changed forms will be given to you displayed where you can see them.*

### **CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS**

The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not disclose to a person outside this facility that a client is attending the program or disclose any information identifying a client as a drug abuser, unless one of the following apply:

1. The client consents in writing.
2. The disclosure is permitted by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violations of Federal law and regulations are a crime and suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal law and regulations do not protect any information relating to a crime committed either at the facility or against any person who works for the facility or about any threat to commit such a crime.

Federal law and regulations do not protect any information relating to suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities.

Reference 42 U.S.C.290dd.3 and 42 U.S.C.290ee.3 FOR Federal law 42 CFR Part 2 for Federal regulations

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## PRIVACY PRACTICES

I am acknowledging that I have received a copy and understand my rights as it applies to the Private Health Information that The Transition House keeps about the services given to me. If I have any questions I understand that I can speak to my primary counselor, or supervisor at the counseling center.

If I have additional questions I can contact the main office:

The Transition House Inc.  
3800 5th Street  
Saint Cloud FL 34769  
407-892-5700

[www.thetransitionhouse.org](http://www.thetransitionhouse.org)

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT FOR TREATMENT**

Before we begin working with you we are required to have your consent for interview. Please read the following statement. I certify that I am participating in an interview with the Outpatient program for services. I give my consent for the initial interview to begin.

I voluntarily agree to participate in The Transition House Treatment Outpatient Program. I understand that my sincere and successful participation in this program will enhance my well-being, as well as promote stability at home, school, and in the community.

Participation in this program is not a guarantee against prosecution or ultimate incarceration. I hereby agree to participate in the Program. The conditions of the program and my responsibilities have been reviewed and explained to me by a Transition House Representative. I have been informed of the services provided by the agency and of my rights pertaining to confidentiality. I understand that this document serves as a formal agreement to accept and participate in services via The Transition House.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **URINALYSIS TESTING**

Urine samples may be requested for the purpose of evaluating treatment needs and/or monitoring treatment progress. Consistent positive urinalysis results may lead to termination of service. Test results are confidential except when consent for release of information has been completed or as legally required. I consent to provide urine samples for testing whenever requested. I understand that the testing may be used to evaluate my need for treatment and/or my progress in treatment.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **CONSENT FOR INTER-AGENCY COMMUNICATION**

I authorize The Transition House to receive or communicate pertinent information related to the client and services being provided during participation in the program. This may include, but is not limited to the exchange of written, including via secure encrypted e-mail, or verbal information with contracted agencies. I understand that this information will be protected and that confidentiality will be safeguarded.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## CONFIDENTIALITY AGREEMENT

The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not disclose to a person outside this facility that a client is attending the program or disclose any information identifying a client as a drug abuser, unless one of the following apply:

1. The client consents in writing.
2. The disclosure is permitted by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Violations of Federal law and regulations are a crime and suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal law and regulations do not protect any information relating to a crime committed either at the facility or against any person who works for the facility or about any threat to commit such a crime. Federal law and regulations do not protect any information relating to suspected child abuse or neglect from being reported under State Law to appropriate

State or local authorities. Reference 42 U.S.C.290dd.3 and 42 U.S.C.290ee.3 FOR Federal law 42 CFR Part 2 for Federal regulations

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **GRIEVANCE PROCEDURE**

Anytime you think that an action taken by a Transition House Representative is unjust or you believed that you are being treated unfairly, or you are dissatisfied with services, you can make a complaint. This complaint is called a GRIEVANCE. To file a grievance, the procedure is as follow:

First, if possible, try to work out the issue with The Transition House Representative and/or their Supervisor. If this is not successful, write out your grievance on a Grievance Form posted by the Grievance Procedure and give to either the Supervisor of your program or a Transition House Representative with whom you feel comfortable. Within fifteen (15) working days, the Supervisor will discuss the grievance with you and try to resolve the matter. The Supervisor will write you as to what, if any action will be taken on your grievance. If you are not satisfied with the Supervisor's decision, you have the right to appeal, in writing, to the Chief Executive Officer or you have the right to request a formal hearing with The Transition House, Inc., the Chief Operating Office, and the CEO. The administration of The Transition House has fifteen (15) working days to review, investigate your grievance, and notify you of their findings and any actions that may be warranted. A final formal hearing would be scheduled at your convenience and a resolution to your satisfaction will be sought as quickly as possible.

You always have the right to take your grievance further to the Tennessee Department of Mental Health and Substance Abuse Services at Complaint Line: (866) 777-1250

**NOTE: NO ACTION WILL BE TAKEN AGAINST YOU FOR FILING A GRIEVANCE**

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## CLIENT'S RIGHT

The following are your rights as a client who has elected to receive services from The Transition House Inc. agency:

- To receive services without regard to race, sex, age, creed, or religion.
- Your personal dignity is recognized and respected in providing care and treatment.
- To not be denied services based solely on race, gender, ethnicity, age, sexual orientation, HIV status, prior service departures, disability, language, socioeconomic status, religion, or relapse.
- The following rights shall be afforded to all clients by all licensees and are not subject to modification:
  - Clients have the right to be fully informed before or upon admission about their rights and responsibilities and about any limitation on these rights imposed by rules of the facility. The facility must ensure that the client is given information about his or her rights that shall include at least the following:
    - A statement of the specific rights guaranteed the client by these rules and applicable state and federal laws;
    - A description of the facility's complaint and grievance procedures;
    - A listing of all available advocacy services;
    - A copy of all general facility rules and regulations for clients; and,
    - The information must be presented in a manner or format that promotes understanding by clients of their rights and an opportunity must be given to clients to ask questions about the information. If a client who is unable to understand this information at the time of admission later becomes able to do so, the information must be presented to the client at that time. If a client is likely to continue indefinitely to be unable to understand this information, the facility must promptly attempt to provide the required information to a parent, guardian, or other appropriate person or agency responsible for protecting the rights of the client;
  - Clients have the right to voice grievances to staff of the facility, to the licensee, and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination or reprisal;
  - Clients have the right to be treated with consideration, respect and full recognition of their dignity and individuality;
  - Clients have the right to be protected by the licensee from neglect; from physical, verbal and emotional abuse (including corporal punishment); and from all forms of misappropriation and/or exploitation;
  - Clients have the right to be assisted by the facility in the exercise of their civil rights;
  - Clients have the right to be free of any requirement by the facility that they perform services which are ordinarily performed by facility staff;



- o If residential services are provided, clients must be allowed to send personal mail unopened and to receive mail and packages which may be opened in the presence of staff when there is reason to believe that the contents thereof may be harmful to the client or others;
- o Clients have the right to privacy while receiving services;
- o Clients have the right to have their personal information kept confidential in accordance with state and federal confidentiality laws;
- o Clients have the right to ask the facility to correct information in their records. If the facility refuses, the client may include a written statement in the records of the reasons they disagree;
- o Clients have the right to be informed about their care in a language they understand; and,
- o Clients have the right to vote, make contracts, buy or sell real estate or personal property, or sign documents, unless the law or a court removes these rights.
- The following rights must be afforded to all clients by all licensed facilities unless modified in accordance with rules 0940-05-06-.07 or 0940-05-06-.08:
  - o Clients have the right to participate in the development of the client's individual program or treatment plans and to receive sufficient information about proposed and alternative interventions and program goals to enable them to participate effectively;
  - o Clients have the right to participate fully, or to refuse to participate, in community activities including cultural, educational, religious, community services, vocational and recreational activities;
  - o If residential services are provided, clients must be allowed to have free use of common areas in the facility with due regard for privacy, personal possessions, and the rights of others;
  - o Clients have the right to be accorded privacy and freedom for the use of bathrooms when needed;
  - o Clients shall be permitted to retain and use personal clothing and appropriate possessions including books, pictures, games, toys, radios, arts and crafts materials, religious articles, toiletries, jewelry and letters;
  - o If residential services are provided and if married clients reside in the facility, privacy for visits by spouses must be ensured, and if both spouses are clients residing in the facility, they must be permitted to share a room;
  - o If residential services are provided, clients have the right to associate and communicate privately with persons of their choice including receiving visitors at reasonable hours; and,

To be assured freedom from neglect, abuse, exploitation or any form of corporal punishment and should you feel that you are being mistreated, contact the Tennessee Department of Mental Health and Substance Abuse Services at Complaint Line: (866) 777-1250



**ABUSE REPORTING POLICY**

Florida Statute 425 requires that any child abuse allegations revealed to any Transition House employee will require that a telephone and/or written report be submitted to the State of Florida Department of Children and Families Abuse Registry. The caller is not responsible for determining the validity of the abuse. I understand that The Transition House Representative will not discourage or prevent me from contacting the Department of Children Services in Tennessee. To report abuse or neglect, call or go online at 1-877-237-0004

[WWW.TN.Gov/dcs/article/report-child-abuse](http://WWW.TN.Gov/dcs/article/report-child-abuse)

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## OUTPATIENT ORIENTATION

Welcome to the Outpatient Center. You are now a voluntary participant in our treatment program. Our vision for you is to provide counseling services to the behavioral health population in a safe and therapeutic environment, which includes addiction education and exploration of client strengths to regain a healthy and productive lifestyle. Our responsibility is to help you by educating you about your illness of addiction and co-existing conditions and to help you explore ways to stay free of illicit drug use and get your life back on track.

We may make recommendations for other services in order to help create full stability of mind, body and soul. We also will provide individualized and group counseling services to enhance this process when deemed necessary.

How the program works:

From admission to treatment, you are evaluated by our counseling staff. This evaluation process includes interviews with you and drug screening as needed to assess clinical needs. Once the initial screening and assessment process is complete, you will be provided a follow-up appointment with the counseling staff. All further appointment needs will be assessed and scheduled at the follow-up visit. Counseling sessions may be required for the first four weeks of treatment pending outcome of initial screening/assessment process.

Program Rules:

The following rules and regulations have been established by the program to ensure that a safe and therapeutic environment is maintained for the benefit of everyone. The examples listed below are not meant to be all-inclusive, but are a representation of the intent.

- Acts of physical violence or threats of violence toward staff or clients will not be tolerated. Physical violence will result in police intervention.
- No abusive, vulgar, or profane language will be permitted while on the premises.
- No overt sexual conduct will be permitted
- Possession and/or use of any type of weapon on clinic premises will be cause for immediate termination and police intervention as deemed necessary. 5) Use of possessions/dealing of any illicit drugs or substance is prohibited on clinic premises and could result in immediate termination from treatment and police intervention.
- Theft of any kind within the program will result in immediate termination and police intervention.
- You must inform the counselor of any prescription drug you may be taking in order to avoid drug interaction/contraindications.
- Loitering or panhandling is not permitted on premises.
- You must provide a urine sample upon request from counselor and will be charged for all urine screenings as listed in the payment policy, if not covered by your insurance.



**Payment Policy:**

The Transition Outpatient Center operates on Health insurance benefits and patient fees for services. Fees are due at the time services are rendered and must be paid in money order, check, or credit card. **NO CASH WILL BE ACCEPTED**

A \$45.00 fee applies to all returned checks. No refunds will be provided for services already rendered.

If any scheduled appointments are missed without at minimum 24-hour notice, the client is responsible for a \$45 cancellation fee.

Additional Fees: (subject to change)

- Substance Abuse Evaluation: \$147.00
- Mental Health Evaluation: \$165.00
- Individual Counseling: \$74.00
- Group Counseling: \$35.00
- Couples Counseling \$110.00
- Psychiatric Evaluation \$350.00
- Psychological Evaluation (depending on type) \$210.00 - \$650.00
- Court representation: \$40 per hour
- Court Probation Reports: \$35.00
- Urine Drug Screen: \$25.00

**Refund Policy**

A refund will be issued if it is an insurance requesting an over -payment refund. Before the request is filed a dispute/appeal must be processed to determine if a refund is genuinely necessary.

A refund will be issued in the case where an individual is a self paying client and has pre paid for services. If the individual cancels within the appropriate time frame that amount will be refunded to the individual.

I am acknowledging that I understand the program rules and payment policies, I am acknowledging that I have received a copy of each of these from an employee at TTHI.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT FOR RELEASE**

I, the undersigned authorize T.T.H.I. to release all client information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which I am being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Transition House, Inc. to any insurance company, and/or third party payers, or representatives providing coverage for this admission, or to any T.T.H.I. representative. I acknowledge that this information may not be released to any other person or entity unless I authorized the TTHI Representative to do so.

I, the undersigned acknowledge that such disclosure shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released. Furthermore, I authorize T.T.H.I to release information for the purpose of obtaining preauthorization for treatment and concurrent review and to release that information to medical review agencies, and/or third party payers, providing coverage or having responsibilities for the admission.

I, the undersigned have been informed by the TTHI Representative the confidentiality of alcohol and drug abuse client records are protected by federal law regulations. Therefore, I understand that T.T.H.I. may not disclose information to anyone outside of T.T.H.I., which would identify any clients as an alcohol or drug abuser unless the client has consented in writing; the disclosure is allowed by a court order, or the disclosure is made to medical or other qualified personnel in accordance with Federal regulations.

I, the undersigned have been informed by the TTHI Representative that the Federal law and regulations do not protect information regarding a crime or a threat to commit a crime or any information regarding suspected child abuse or neglect from being reported to appropriate State or local officials.

I, the undersigned hereby authorize free exchange of medical record information, including but not limited to the release of client information indicated above, between T.T.H.I and the attending therapist, his/her group practice association and/or other health care agencies, facilities and/or professionals which may provide services to clients during this admission. This includes the authorization to discuss the client's specific information indicated above with a TTHI Representative.

I, the undersigned acknowledge his/her right to request and receive a copy of this authorization for release of information and may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. Furthermore, the undersigned acknowledges that this authorization shall be valid until all third party payers liable are evolved for this admission of service.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**GUARANTEE OF PAYMENT**

I the undersigned, hereby agree to guarantee the payment of the bills for services rendered by The Transition House, Inc. Also, I agree to sign as guarantor or as client that in consideration of the serviced to be rendered to me, to be hereby jointly and individually obligated to pay the account of T.T.H.I. in accordance with the regular rates and terms of T.T.H.I. I understand that if the account is referred for collection by an attorney or collection agency, I will be responsible to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any account(s) not paid when due.

In consideration of the treatment and services rendered or to be rendered, by The Transition House, Inc. to the extent permitted by law, I hereby irrevocably assign, transfer and set over to T.T.H.I. (II) all of my rights, title and interests to medical reimbursement, including but not limited to, (III) the right to designate a beneficiary, add a dependent, eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreements otherwise payable to me for whose services rendered by T.T.H.I. during the dependency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery of said policy (s) of insurance, but shall not be construed to be an obligation of T.T.H.I. to pursue any such right of recovery. I hereby authorize the insurance company's) or third party payers) to pay directly to T.T.H.I. all benefits due for services rendered.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**ADVANCE DIRECTIVES**

**ADVANCE DIRECTIVE ACKNOWLEDGEMENT**

The undersigned acknowledges the following: I have been given written materials about my right to accept or refuse treatment: I have been informed of my rights to formulate Advance Directives. I understand that I am not required to have an Advance Directive in order to receive treatment at this facility I understand that the terms of any Advanced Directives that I have executed will be followed by the facility and the employees of T.T.H.I to the full extent of the law. PLEASE CHECK ALL THAT APPLY:

Yes, I have a Medical advance directive

No, I do not have a Medical advance directive

Yes, I have a psychiatric advanced directive

No, I do not have a psychiatric advanced directive

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_