CROSSROADS INTAKE INFORMATION SHEET

ACCOUNT #_____

CLIENT NAME:_____ AGE:_____ BIRTHDATE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

(All mailings are sent to address provided, billing statements are combined if there is more than one family member at the address listed unless otherwise indicated))

PHONE #: (H)_____ (CELL)_____ (W) _____May we call your work? Y____ N____

(EMAIL)_____ S.S.#:_____ Preferred method of contact? EMAIL or Phone

GENDER: M____ F____ MARITAL STATUS: S____ M____ D____ SEP____ W____ DOM. PART. ____ Education: _____(yrs)

Primary Language: _____ Disability (Hearing, Vision, Physical) _____

RACE: Cau____ African Am/African____Native Am Indian____Native AmHawiian____Asian____ Other____ More than one Race_____ ETHNICITY*: non*-Hispanic/Latino____ Hispanic/Latino _____

REFERRED BY:_____ EMPLOYER: _____

CURRENT SCHOOL ATTENDING (If Client is a Minor):_____ GRADE:_____

Minor Guardians Name: _____ Relationship to client:_____

Address if different from above:_____

EMERGENCY CONTACT PERSON: Name:_____ Phone: _____

Address:_____ Relationship to Client:_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO:_____

Subscriber #:_____ Group #:_____Name of Insured:_____

Birthdate:_____ S.S. #:_____ Address: _____

City: _____ State:_____ Zip:_____Phone #: (H)_____ (W)_____

Employer:_____

SECONDARY INSURANCE CO:_____

Subscriber #:_____ Group #:_____Name of Insured:_____

Birthdate:_____ S.S. #:_____ Address: _____

City: _____ State:_____ Zip:_____Phone #: (H)_____ (W)_____

Employer:_____

PLEASE LIST THE CLIENT'S FAMILY MEMBERS LIVING IN THE HOUSEHOLD AND SPECIFY RELATIONSHIP:
***USE BACK OF PAGE IF NECESSARY**

NAME	BIRTHDATE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHO ARE YOU SEEING TODAY?_____ Date:_____

****THIS PAGE IS ONLY FOR EAP CLIENTS OR UNDERAGE DRINKING TICKETS****

EMPLOYEE ASSISTANCE ONLY

FILL OUT BELOW ONLY IF PERSON SIGNING THE PAPERWORK IS NOT EMPLOYEED AT THE COMPANY PROVIDING EAP

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE PERSON WHO IS EMPLOYED AT THE COMPANY (IF CLIENT BEING SEEN TODAY IS SPOUSE OR DEPENDANT)

EMPLOYEE NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE_____ ZIP_____

PHONE (HOME):_____ CELL: _____ WORK: _____

GENDER: M_____ F _____ SOCIAL SECURITY #: _____

MARTIAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOW _____ SEPAR,_____

ETHNICITY: CAU____ HISPANIC ____ BLACK ____ NAT. AMER._____ ASIAN _____ OTHER _____

EMPLOYMENT INFORMATION

EMPLOYER NAME: _____

EMPLOYEE ADDRESS: _____

CITY: _____ STATE:_____ZIP: _____

POSITION: _____ YEARS OF SERVICE: _____

PHONE NUMBER: _____ CONTACT PERSON: _____

UNDERAGE DRINKING TICKET ONLY

FLAT FEE OF $75.00

_____PAID _____NOT PAID

_____TICKET _____ NO TICKET

CROSSROADS POLICY FOR PAYMENT OF SERVICES

Crossroads, as a courtesy, will submit an insurance claim to your insurance company using the information you have provided. Crossroads is **not** responsible for the outcome of the claim submission. If payment is incorrect or your insurance company fails to respond to the claim it is **your** responsibility to contact the insurance company. If it is necessary to resubmit a claim we will be happy to do so at your request.

Please read and initial each statement and sign below.

↓

_____ I am responsible for contacting my insurance company to find out if services at Crossroads will be covered by obtaining benefit information, including any necessary authorizations or referrals.

_____ I am responsible for contacting my insurance company in the event I have questions regarding benefits, payments and coverage.

_____ I am responsible for all charges and agree to pay them within 90 days of service regardless of insurance status; all outstanding balances (regardless of dollar amount) will be sent to a contracted collection agency for failure to pay the account balance after 90 days. I am responsible for co-payments at the time of each service. If no insurance is involved, I am responsible for payment at time of service. *I also understand that failure to do so may interrupt therapy*.

_____ I am responsible for payment of late cancellations (less that 24 hour notice) and no call/ no show appointments. I understand my insurance will **not** pay for these charges.

_____ In the case of a minor (child) involved in services, the adult signing our intake paperwork is responsible for all charges regardless of legal documents.

_____ When I have questions regarding my bill, I will contact the Billing Department at 755-5260. The Billing Department hours are 8:00am to 4:00pm. Monday -Thursday.

* Mental Health clients Must be 18 years or older to sign this document (AODA clients 15-17 years of age can sign)

_____ _____

Signature Date

A copy of this agreement will be provided to you at your request.

CrossRoads Counseling Center ***Services Contract***

I. CLIENT FEES

i. **Financial Policy**- It is the policy of CrossRoads Counseling Center that the client is responsible for payment of all fees for services provided according to the fee structure outlined in this Services Contract.

ii. **Insurance**- Claims will automatically be filed with the insurance company information provided. However, clients are responsible for settlement of any disputed charges and/or non-covered services with their insurance company. All outstanding balances are due and payable within 90 days or they will be sent to an outside collection agency.

iii. **CLIENTS COVERED BY MANAGED CARE/HMO'S (EXAMPLE: DEANCARE-TPA) - It is the clients responsibility to obtain all necessary referrals/authorizations for services provided by CrossRoads. Failure to do so will result in the client being responsible for all charges not covered by such authorizations.**

iv. **Private Payments/Co pays/Deductibles**- All such payments are due and payable at the time of each appointment.

v. **Monthly Statements**- Clients who have out-of-pocket balances will receive monthly statements. If you note any discrepancies, please contact our Billing Department at 608-755-5260.

vi. **Minor Children**- Any parent who brings a minor child to CrossRoads will be held responsible for any out of pocket expenses incurred regardless of court-ordered financial agreements.

vii. **NO-SHOW/MISSED APPOINTMENTS**- **The client/guardian agrees to maintain the recommended therapy schedule * more than one no call no show/late cancel can result in clinic discharge.**

II. APPROXIMATE FEE SCHEDULE - (Fees may vary between individual providers and specific services)

Level of Service	*MD/PA-C/APNP	PhD	LPC/LCSW/SAC	Late Cancel/No Show
Initial Evaluation	$255	$220	$185	Full Fee for MD
Individual Ongoing Therapy		$205	$180	$84/Hr. LPC/LCSW/SAC $115.00/Hr. PhD/EdD
½ Hour Psychotherapy *Medication Management	$160	$105	$90	
Group Therapy				
60-90 Minutes	N/A	N/A	$60	$30
91-120 Minutes	N/A	N/A	$80	$50
121-180 Minutes	N/A	N/A	$120	$70
CADT- Day Treatment	N/A	N/A	$75/hr.	
TMS (Initial MD Mapping)	*$400	N/A	N/A	
TMS (Per TMS Treatment)	N/A	N/A	*$244	

*Refer to TMS treatment provider and billing dept. for complete itemized list of fees

Testing				
Initial Psychological Screening	N/A	$185	N/A	N/A
Neuropsychological Testing (PER HOUR)	N/A	$150-$225	N/A	N/A

I understand and accept full responsibility for services rendered to myself and/or dependents according to the above conditions and Fee Schedule. I also authorize all benefits provided by my insurance plan(s) to be paid directly to CrossRoads on my or my dependents behalf. To obtain Insurance authorizations/referrals and to process insurance or other payment claims including charges for laboratory services, I further authorize CrossRoads to release any necessary medical information, including diagnosis, clinical assessment, treatment and attendance information. This release will will remain in effect until all applicable insurance payments have been received.

_____ _____

Client/Responsible Party Date

_____

Witness Initials

******CLIENT COPY***CLIENT COPY***PLEASE KEEP THIS*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY******

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(signature on file at facility-clients copy) _____

Client/Responsible Party Date

******CLIENT COPY***CLIENT COPY*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY******

CrossRoads Counseling Center **General Information**

I. **Clinic Standards** --CrossRoads Counseling Center is certified by the WI Department of Health & Social Services. The state has developed outpatient psychotherapy clinic standards to ensure that quality services are provided to clients. As required by these standards, personnel employed by CrossRoads are under the supervision of a licensed psychiatrist, psychologist &/or clinical collaborative supervision model. The supervising staff will review client progress, this review may or may not include the client meeting with the psychiatrist, &/or psychologist.

ll. **Client Rights--** At intake, clients are given a copy of the Client Bill of Rights. Any questions or concerns regarding client rights should be directed to their primary therapist and/or the Clinic Administrator.

Ill. **Grievance Procedure--** Should a client feel any of their rights have been denied, they may institute an informal or formal grievance as follows:

1 Discüss the situation with their primary therapist(s) and/or CrossRoads Administrator, Tim Perry. This is the informal grievance procedure. Resolution occurs when the party is satisfied that the situation has been remedied. Grievants may bypass the informal grievance procedure and institute a formal grievance if they so choose. Informal grievances may be presented verbally or in writing.

2 If further resolution is deemed necessary, the client(s) must complete the CrossRoads Counseling Center Grievance Form and submit it to CrossRoads Client Rights Specialist, Mary Cefalu. This is the beginning of the formal grievance process.

3 CrossRoads Client Rights Specialist will conduct a thorough investigation of the grievance. A meeting with CrossRoads Executive Committee will be scheduled by the Client Rights Specialist to present the grievance and to advise the committee of any proposed action to be taken.

4 Final determination rests with the Executive Committee. The Executive Committee will provide the grievant a written statement of its findings and any action taken. A notice of the grievant's appeal rights will also be given to them.

5 County-referred clients are encouraged to file their grievance with the Rock County Human Services Department concurrently with the CrossRoads filing.

6 Grievances may also be filed with the State of WI, Division of Community Services, Regulation & Licensing Section, (608)248-2415. 3601 Memorial Dr., Madison, WI 53709.

IV. **Confidentiality Statement** CrossRoads Counseling Center follows state mandates regarding confidentiality of treatment as outlined in the WI Administrative Code (92). In general, services provided to clients at CrossRoads remain strictly confidential. No information regarding the use of these services will be given without the client's expressed written consent. There are some exceptions to this, CrossRoads has a legal obligation to break confidentiality in cases of Suicidality, homicidality, if the court orders release of clinical records and in cases of child abuse.

V. **Cancellation** -- CrossRoads schedules client appointments so that clients will have the undivided attention of their clinician. When clients must cancel their appointment, CrossRoads requires at least 24 hours notice. After business hours, clients can leave a message of cancellation notice with our 24 hour answering machine. No-Show appointments are not covered by insurance and will result in out-of-pocket charges to the client according to our Fee Schedule. Exceptions may be made when true emergencies due to circum stances beyond the client's control occur: if this happens, notify us as soon as possible.

VI. **Hospitalization Process** -- If hospitalization is required CrossRoads maintains hospital admitting privileges at Mercy Hospital in Janesville.

I have read the above policies and procedures regarding Clinic Standards, Client Rights, Grievance Procedures,Confidentiality and Cancellation Policies. I consent them. Any exceptions or variations must be approved by CrossRoads Administration.

_____ _____

Client/Responsible Party Date

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Witness Initials

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(signature on file at facility-client copy)
Client/Responsible Party

Date

Witness Initials

******CLIENT COPY***CLIENT COPY*** PLEASE KEEP THIS*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY******

MEDICAL HISTORY REVIEW

Client Name:_____ **Date:**_____

Dear Client:

In an effort to better assess your needs and to design a plan of care which is tailored to meet them, we would like the following information about your past and present medical status. If you have questions or if you would like these problems to be further addressed, please bring this to the attention of the clinician who will meet with you today. Thank you for your cooperation!

1. Please list any childhood illness:_____

2. Please list any surgeries you have had (and dates):_____

3. Please list any hospitalizations (and dates): _____

4. Have you ever had any broken bones? (please include dates): _____

5. Have you ever been injured in a car accident? (describe injuries): _____

6. Describe any serious medical condition for which you were treated in the past: _____

7. Are you currently being treated for any medical condition? (describe type of treatment, including medications):

8. Do you have any allergies to medications or to substances? (Dust, pollen, etc.) _____

N:tina/intakeforms/medicalhistoryreview

ACKNOWLEDGEMENT OF RECEIPT OF CROSSROADS

PRIVACY NOTICE AND CLIENT BILL OF RIGHTS

For office use only:

Patient Name: _____

Medical Record #: _____

By signing this form, you acknowledge that CrossRoad's has given you a copy of its Privacy Notice and its Client's Bill of Rights. These copies explain how your health information will be handled in various situations and our services available to clients without discrimination. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[X] I have received CrossRoad's Privacy Notice.

[X] I have received CrossRoad's- Client Bill of Rights

[X] CrossRoad's has given me the chance to discuss my concerns and questions about the privacy of my health information and my Client Rights.

_____ _____

Patient's Signature Date

_____ _____

Other Authorized Signature Relationship to Patient

CrossRoad's staff should complete below information if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice and Client Bill of Rights? [ ] Yes [ ] No

Please explain why the patient was unable to sign an acknowledgement form and CrossRoad's efforts in trying to obtain the patient's signature:

_____

N:Tina/Intakes/acknowledgementofreceiptof crossroads

******CLIENT COPY***CLIENT COPY*** PLEASE KEEP THIS*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY******

A GENERAL DISCRIPTION NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY- SOME INFORMATION MAY NOT BE APPLICABLE TO MENTAL HEALTH AND SUBSTANCE ABUSE CLINIC SETTINGS

CROSSROADS must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. **In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure.** However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

1. Treatment: For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.

2. Payment: In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.

3. Health Care Operations: We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

In addition, we may want to use your health information for appointment reminders. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder letter to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you. For example, we may contact a cancer patient to notify them that we have a new cancer research facility that offers new life-saving treatments.

Furthermore, we may want to use information found in your medical record, such as your name, address, phone number and treatment dates, to contact you for our fund-raising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation.

4. As required or permitted by law: Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

5. For public health activities: We may be required to report your health information to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

6. For health oversight activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

7. For activities related to death: We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

8. For organ, eye or tissue donation: We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.

9. For research: Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

10. To avoid a serious threat to health or safety: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

11. For military, national security, or incarceration/law enforcement custody: If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

****** CLIENT COPY***CLIENT COPY*** PLEASE KEEP THIS*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY*** *** CLIENT COPY***CLIENT COPY*** PLEASE KEEP THIS*** CLIENT COPY*** CLIENT COPY*** CLIENT COPY******

12. For workers' compensation: We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

13. For CROSSROADS' *directory: *Very Rare…Unless you object, we may use your health information, such as your name, location in our facility, your general health condition (e.g., "stable," or "unstable"), and your religious affiliation for our directory. It is our duty to give you enough information so **you** can decide whether or not to object to release of this information for our directory. The information about you contained in our directory will be released to people who ask for you by name. However, the information about your religious affiliation will only be disclosed to clergy. We would allow you to agree or disagree orally regarding the use of your health information for directory purposes, prior to release/use.

14. To those involved with your care or payment of your care: If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release important health information about you to those people. The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information so you can decide whether or not to object to release of your health information to others involved with your care.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to Mary Cefalu, the Privacy Officer.

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact Mary Cefalu, the Privacy Officer. Specifically, you have the right to:

1. Inspect and copy your health information: With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.

2. Request to correct your health information: If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

3. Request restrictions on certain uses and disclosures: You have the right ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction.

If you receive certain medical devices (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the medical device.

4. As applicable, receive confidential communication of health information: You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

5. Receive a record of disclosures of your health information: In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

6. Obtain a paper copy of this notice: Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically. **[IF PROVIDER MAINTAINS A WEB SITE THAT PROVIDES INFORMATION ABOUT PROVIDER'S CUSTOMER SERVICES OR BENEFITS, PROVIDER MUST POST ITS NOTICE ON THE WEB SITE AND MAKE NOTICE AVAILABLE ELECTRONICALLY THROUGH THE WEB SITE. AS A RESULT, PROVIDER MAY WANT TO INDICATE HERE THE AVAILABILITY OF THE PRIVACY NOTICE ON ITS WEB SITE.]**

7. Complain: If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact Mary Cefalu, the Privacy Officer, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact Mary Cefalu, the Privacy Officer at 608-755-5260.

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CROSSROADS COUNSELING CENTER, INC.
CLIENT BILL OF RIGHTS

Our services are available to clients without regard to race, religion, sex, national origin, handicap, and, for life-threatening situations, the ability to pay.
Statement of Client Rights:

Prior to initiation of treatment, clients have the right to know:

1. About the services available at the Center, their costs, and any limitations on their availability.

2. About client rights, in written and oral form, and any regulations about client responsibilities relative to these rights.

3. Information about staff members involved in their care including names, qualifications and responsibilities.

While in treatment, clients have the right to:

1. Be treated with dignity and respect in a humane environment.

2. Prompt, individualized treatment available within the resources of the facility.

3. Treatment by qualified, competent staff members.

4. Treatment in the least restrictive setting necessary to achieve the purpose of admission and which allows the maximum amount of personal and physical freedom.

5. A thorough explanation of the benefits and risks associated with receiving or withholding proposed treatment, including:

   a. The way treatment is to be administered.
   b. The expected side effects or risks of treatment.
   c. Alternative treatment modes.

6. A thorough explanation of the process of informed consent including their right to withdraw informed consent at any time in writing.

7. Participate in planning and reviewing their treatment plan which may include meeting with the supervising psychiatrist or psychologist.

8. Request a second consultation for review of their treatment plan if they disagree with all or any part of the plan.

9. Refuse any treatment, including medication, except in an emergency or if court ordered under the following conditions:

   a. If the prescribed treatment is refused and no alternatives are available within the facility, it is not considered coercion if the Center indicates that the client either participate in treatment or be discharged from the Center, and

   b. The Center shall counsel the client and when possible, refer to another treatment resource prior to discharge.

10. Review their medical records and upon payment of fees for photocopying, may obtain copies of their records.

11. Access to the Center's Client Rights' Grievance Procedure (copy furnished upon request).

12. Be informed of those situations in which their client rights may be denied and access to the Center's policies for having those rights restored.

While in treatment, these confidentiality rights apply:

1. Clients may not be taped, recorded, filmed, or photographed by the Center unless the client grants written authorization for these activities.

2. Clients may not be involved in any form of research or drastic treatment measures without the informed consent of the client, approval of the primary therapist and until a decision is made by the Clinical Director that conditions and requirements of Chapter HSS 94 protecting the client's rights and privacy are satisfied.

3. CrossRoads Counseling Center may not disclose any medical information about the client unless the release of information is required by law. However, clients may authorize the facility to disclose information by signing the proper release forms.

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CROSSROADS COUNSELING CENTER, INC.
CLIENT BILL OF RIGHTS continued

While in treatment, rights may only be denied as follows:

1. Good cause for denial or limitation of rights exists only when the administrator of the Center or designee has reason to believe the exercise of the right would create a security problem,

adversely affect the client's treatment, or seriously interfere with the rights or safety of others.

2. At the time of denial or limitation of rights, written notice shall be provided to the client or guardian/parent, and a copy of that notice shall be placed in the patient's treatment record. The notice shall specify the reason for the denial or limitation, expected duration of the denial, and specific conditions required for restoring rights. Written copies shall be sent to the county's complaint investigator (for County Department clients), and the Center's complaint investigator (Clinical Director), within 2 calendar days following denial of rights.

3. At the time of denial of rights, the client or guardian/parent is informed of their right to an informal hearing with the Center's administrator within 3 days including the need to submit a written request for same. The director will consider all relevant information and the final decision will be rendered by the Executive Committee.

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