People in Need
...the one stop center for social services
2703 West State Street, New Castle, PA 16101
Phone: 724-657-3303 Fax: 724-657-3326 www.pinpa.org

Greetings:
Thank you for your interest in our agency.
We look forward to helping you meet your mental health goals

* Please fill all forms out **COMPLETELY**. If a question does not apply, please mark it as "NA" or "None". This will ensure that there is enough time at your initial session for you to express your concerns.

* If you are a parent seeking services for your child, please note that individuals **14 years of age** and older **MUST** sign all forms themselves.

* Parents can of course provide the relevant information for the referral, but adolescents are required to give their own consent and indicate understanding of confidentiality and other aspects related to being a recipient of mental health services.

Once we have received your **fully completed** paperwork, we will contact you to schedule an appointment with one of our therapists.

Thank you again for choosing People In Need

PEOPLE IN NEED APPOINTMENT INFORMATION

Child

Date: _____

First Name: _____ Middle Initial: _____

Last: _____

Check One: Married: _____ Single: _____ Divorced: _____ Separated: _____ Widow: _____

Age: _____ Sex: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____

Parent/Legal Guardian (if under 18): _____

Home Address: _____

Please contact me by:

Home Phone: _____ Cell Phone: _____

Email: _____

Pharmacy Used: _____ Phone#: _____

Insurance Company Name: _____

Insurance ID#: _____ Phone#: _____

Policy Holder's Name: _____ Date of Birth: _____

**Brief description of the reason for your visit or appointment request:

_____

_____

_____

Client Case #_____

People In Need
Child Intake Information Form
(17 years old and under)

Date: _____ Child Name: _____ Age: _____ Date of Birth: _____

Sex: ____ Pronouns: _____ Social Security Number: _____-_____-_____ Email: _____

Home Address: _____

Home Phone: _____ Referred by: _____

Is Child Adopted? ☐ No ☐ Yes, at what age? _____ Is Child in Foster Care? ☐ No ☐ Yes, how long? _____

Parents' Marital Status: ☐ Never Married ☐ Married Date: _____ ☐ Separated Date: _____
☐ Divorced Date: _____ ☐ Widowed Date: _____

Biological Mother's Information:

Name: _____ Home Phone: _____

Address (if different from child): _____

Occupation: _____ Employer: _____ Business Phone: _____

Biological Father's Information:

Name: _____ Home Phone: _____

Address (if different from child): _____

Occupation: _____ Employer: _____ Business Phone: _____

Other caregivers/guardians (e.g. step-parents, adoptive parents, foster parents, extended family members):

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Please describe the reason for your visit:

_____

_____

_____

Family and Household Composition: (List child's immediate family and significant relationships, e. g. siblings, step-siblings, grandparents). In *Location* column, write **H** for people living with child and write city/state of residence for people not living with child. Under *Health Issues,* write any serious illness or injuries.

Name	Relationship	Age	Location	Health Issues

Custody Information:

Describe the physical and legal custody agreement (e.g. shared custody, visitation schedule, guardianship):

_____

_____

_____

_____

Please describe any pending legal matters (e.g. ongoing visitation/custody proceedings, truancy):

_____

_____

_____

Educational History:

School: _____ City: _____ Phone: _____

Grade: _____ Teacher(s): _____

Placement: ☐ Mainstream ☐ Gifted/Honors ☐ Retention, what grade? _____

☐ Special Education (IEP), type: _____ ☐ Other Services _____

Describe strength and problem areas (friendships, behavioral concerns, academic concerns, interactions with teachers):

_____

_____

_____

Please list any significant stressors that your child/family have experienced (accidents, deaths, moves, school or job change, illness/injury, violence, crime victimization, etc.): _____

_____

_____

_____

History of Sexual, Physical or Psychological Abuse:

☐ Sexual abuse ☐ Raped ☐ Victim/witness of domestic violence

☐ Physical abuse ☐ Psychological abuse ☐ Sexual activity with a family member or relative

Has the child ever experienced any kind of sexual, physical, or psychological abuse (nature of abuse, duration, age, people involved, and charges filed/reporting of incident)?

_____

_____

_____

_____

Please list any previous MENTAL HEALTH SERVICES (outpatient/inpatient) your child has received:

Provider/Agency	**Dates**	**Reason**

Please list any SYSTEMS INVOLVEMENT and/or intervention (social services, CYS, early intervention):

TYPE OF INVOLVEMENT	DATES	OUTCOME

Health Information

Primary Care Physician: _____ Height: _____ Weight: _____

Has the child had any seizures or convulsions: ☐ No ☐ Yes, please explain when and what caused them:

_____

Allergies: ☐ No ☐ Yes, please list: _____

Current health problems or concerns:

PROBLEM/CONCERN	HOW LONG	NAME OF TREATING DOCTOR

Medical Hospitalizations (especially involving head/neck/spine):

FOR SURGERIES	OUTCOME/STATUS	DATE(S)

FOR MAJOR ILLNESS/INJURY	TREATMENT/OUTCOME	DATE(S)

Family Psychiatric/Medical History (major illness or disease that runs in the family):

FAMILY MEMBER(S)	ILLNESS/DISEASE	TREATMENT	STATUS/OUTCOME

Current Medications/Medications taken within the year (prescribed and non-prescribed):

MEDICATION	DOSE/FREQUENCY	REASON	SIDE EFFECTS

Sexual Identity/Sexual Orientation *(check all that apply):*

☐ Straight (heterosexual) ☐ Asexual ☐ Bisexual ☐ Gay ☐ Lesbian

☐ Prefer not to disclose ☐ Pansexual ☐ Queer ☐ Questioning or Unsure

☐ An identity not listed: please specify _____

Gender Identity *(check all that apply):*

☐ Male ☐ Transgender ☐ Non-Binary ☐ Gender Fluid ☐ Genderqueer

☐ Female ☐ Agender ☐ Androgyne ☐ Bigender

☐ Questioning or Unsure ☐ Prefer not to disclose ☐ An identity not listed: please specify

_____

Lifestyle/Health Habits:

List any past or present bowel/urinary problems (bed wetting):_____

_____

Hours of sleep per night: _____ Describe any sleep problems: _____

_____

Exercise/physical activities (how often, how long, what type):_____

_____

Describe any problems with appetite: _____

Any significant changes in weight (20+ lbs. in 6 months): ☐ No ☐ Yes if yes, please describe and give any reasons for change: _____

Interests/Hobbies:_____

_____

Substance Use History (please check all past/present use):

Average daily consumption of coffee, tea, cola, or other caffeine: _____

☐ No tobacco use ☐ Former tobacco user who has quit, when: _____

☐ Tobacco user (cigarettes, cigars, chew, snuff, e-cig) Average daily tobacco use:_____

Substance	Age at first use	Date of last use	Frequency/Length	Method	Quantity
Alcohol					
Tranquilizers (Ativan, Xanax)					
Marijuana					
Heroin					
Other opiates (OxyContin, Vicodin, Percocet)					
Cocaine/Crack					
Methamphetamine					
Amphetamine (speed)					
LSD					
MDMA (ecstasy)					
PCP					
Inhalants					
Over the Counter (cough syrup, caffeine pills)					

Client Signature *(if applicable)*: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: Date of Referral:

PHQ9 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**		0 Not at all	1 Several Days	2 More than half the days	3 Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**	0 Not at all	1 Several Days	2 Over than half the days	3 Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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PEOPLE IN NEED TREATMENT PLAN AND ATTENDANCE POLICY

Our mission is to help you achieve your goals and foster improvement in your mental health while providing a welcoming and comfortable atmosphere. We provide therapy, evaluation, and in appropriate cases, we provide medication management. The treatment process is as follows:

1. Each patient is required to see a therapist for an intake interview. The therapist will go over with you information from your intake paperwork. They will discuss confidentiality and explain that each patient has their own treatment plan. The therapist will open your case and evaluate current needs which will be addressed in your treatment plan.

2. The treatment plan will include your goals and steps to be taken to achieve them. You will meet with your therapist monthly or perhaps more often, depending on when you and your therapist agree to meet. If you must reschedule an appointment, you must call at least 48 hours ahead of time.

3. If you miss three appointments, without prior cancellation, your case will be closed and you will be discharged from our services. At a later date you may ask to be reinstated as a patient.

4. Your therapist may recommend that you have a Psychiatric Evaluation by our Nurse Practitioner/Doctor.

5. You will continue to see your therapist at least on a monthly basis until such time that the therapist and Nurse Practitioner/Doctor agree that you have met the goals of your treatment plan. When all therapeutic goals have been met, you may continue to receive medication management services only. If your therapeutic needs change with time your Nurse Practitioner/Doctor may ask you to return to therapy in collaboration with medication management.

6. If you are prescribed medication, you will meet with the Nurse Practitioner/Doctor as directed. The timing of the appointments will depend on the medication you receive and the expert opinion of the Nurse Practitioner/Doctor. You may reschedule appointments as needed 48 hours in advance. If you miss three appointments, without prior cancellation, your case will be closed and you will be discharged from our services. At a later date you may request to be reinstated as a patient.

7. The ability to have medication management appointments only, is contingent upon compliance with therapy and your overall progress. Studies have shown that in mental health treatment, a combined approach of medications and psychotherapy produces the best results. Therefore in order to have the most success and best experience possible in your journey to mental health recovery, we ask that you follow your Treatment Plan and the Attendance Policy of People in Need.

SIGNING BELOW VERIFIES THAT YOU UNDERSTAND AND AGREE TO OUR PROCEDURES AND POLICY REGARDING THERAPY AND APPOINTMENTS AT PEOPLE IN NEED.

Therapist's Signature_____ Date_____

Patient's Signature_____ Date_____

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Medication Management Agreement

To provide the best quality psychiatric care to our patients, there will be an agreement between the patients and the Psychiatrist/Practitioners regarding prescribed medications.

Please initial after reading each statement:

_____ I understand that medication prior authorizations may take several days to complete due to insurance review.

_____ I am responsible for my medication. If a controlled substance medication is lost, misplaced, stolen or if I need it refilled sooner than prescribed, I understand it will not be replaced.

_____ I will not request or accept the same class of medication from any other physician/ prescriber while I am receiving medication from this office, unless agreed upon by both prescribers in writing.

_____ Refills of medications:

- Will only occur during regular office hours.
- Will not be authorized early because of vacations or personal plans.
- Will not be authorized by our staff in any emergency room or urgent care facility.
- Must be requested at least 72 hours prior to running out of medications.

_____ I am responsible for taking my medication at the dose and time prescribed.

_____ I will not share, trade, or sell my medications. I understand that doing so will result in my immediate discharge.

_____ I will disclose fully to the best of my knowledge all other medications I am taking, including methadone, suboxone, opiates and other pain medication. I understand mixing certain classes of controlled substances may be deadly and it is my responsibility to make my practitioner aware at each appointment and refill request of any medication changes.

_____ I agree to comply with random medication monitoring for controlled substances which may include: drug screening, pill counts and electronic database monitoring. I understand failure to comply may result in medication discontinuation.

_____ I understand that driving a motor vehicle or operating heavy machinery may not be allowed at times while I am taking a controlled substance and it is my responsibility to comply with the laws of this state and in accordance with my prescriber.

_____ I understand that if any criminal charges for receiving, possession or selling of illegal substances and/or a controlled substance prescription will be reviewed by my prescriber and may result in my discharge.

_____ I understand that I must be compliant with medication management appointments to receive ongoing prescriptions.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All questions and concerns regarding this form and my treatment have been adequately answered. If I do not follow these guidelines, Psych-Med Associates has the right to taper and/or discontinue my medication and discharge me from this office with alternative referrals.

Patient Signature: _____ Date: _____

Parent/Guardian (if under 18): _____ Date: _____

Witness Signature: _____ Date: _____

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I, (Member Name) _____, have been informed that I have The right to choose a mental health provider. I have had the opportunity to discuss my Treatment/service needs with (Staff Name)_____, who informed me of The choices available and if necessary, has offered to assist me to schedule an appointment. I have Been advised that if I would like to discuss further options for treatment I can call:

Carelon Behavioral Health

Armstrong/Indiana County	877-688-5969
Beaver County	877-688-5970
Butler County	877-688-5971
Crawford/Mercer/Venango County	866-404-4561
Fayette County	877-688-5972
Lawrence County	877-688-5975
Washington County	877-688-5976
Westmoreland County	877-688-5977
TTY (Hearing Impaired)	877-688-8502

Member's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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CLIENT RIGHTS FORM

1. I understand that I have the right to decide not to enter therapy (although depending on my situation there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue.
2. I understand that I have the right to a safe environment during therapy, free from physical, sexual, and emotional abuse.
3. I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress.
4. I understand that I have the right to information about the professional capabilities and limitations of any clinician(s) involved in my therapy, including their certification/licensure, education and training experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive.
5. I understand that I have the right to written information about fees, payment methods, co-payments, length and duration of sessions and treatment.
6. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status.
7. I understand that I have the right to request the release of my clinical information to any agency or person I choose.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT'S GRIEVANCE (COMPLAINT) PROCEDURE

If you have a complaint regarding services or mistreatment by the agency staff, you have the right to file a verbal or written complaint.

Address your complaint to:

SHARON HODGE, PhD.
EXECUTIVE DIRECTOR
2703 WEST STATE STREET
NEW CASTLE, PA 16101
(724) 657-3303
HOURS: 8:30 A.M. TO 4:30 P.M. MONDAY – FRIDAY

You may inform any agency staff member that you wish to register a complaint; and that you would like to talk to the Executive Director. The agency worker shall inform the Executive Director immediately. The Executive Director will try to see you as soon as possible, but no later than two working days after you request the interview. The Executive Director shall enter your request in the grievance log. The Executive Director will act in your behalf and will try to resolve your grievance. You will be assisted by the Executive Director in filing the necessary papers. The Executive Director will investigate, provide a response, if possible, continue the grievance, represent you if you so wish, and collect all the data to document your case. If the complaint is against the Executive Director, an Alternate Client Rights Officer shall conduct the investigation.

The aggrieved may be a client or a non-client. A grievance may be filed at any time. It is strongly recommended that the person file such a grievance as soon as it occurs because the data will be fresher and thus easier to investigate. The designated person to serve as a Client Rights Officer is Sharon Hodge, Executive Director. The Alternate Client Rights Officer is Joannie Garrett, Business Manager.

These are the procedures that will follow your contact with the Executive Director:

1. The complaint form is completed and the Executive Director will investigate the complaint. A written response will be given to the client of the findings no later than five (5) working days after the initial complaint. If the client is satisfied, the complaint is considered resolved and no further action is taken.
2. If the client is not satisfied with the decision, the client will meet with the Executive Director and the Alternate Client Rights Officer to try to resolve the impasse. A written response will be forthcoming within ten (10) working days of the meeting. If the client is satisfied, the complaint is considered resolved and no further action is taken.
3. If resolution cannot be reached within the agency, the client is advised in writing and referred to all the following outside sources within twenty (20) working days of the initial agency complaint:

You may address your complaint to:

Office for Civil Rights - Region III
U.S. Department of Health & Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-3499

Bureau of Equal Opportunity
Department of Public Welfare
Health and Welfare Building Room 521
Harrisburg, PA 17105-2675

Pennsylvania Human Relations Commission
11th Floor State Office Building, 300 Liberty Avenue
Pittsburgh, PA 15222

I attest that I have received a copy of Client Rights and Client's Grievance Procedure and that I fully understand my rights as specified therein.

_____ _____
Client/Guardian Signature Date

_____ _____
Agency Staff Signature Date

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CONSENT FOR TREATMENT

1. I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with this therapy. With that knowledge, I request and consent to receive therapy from qualified personnel of this agency.
2. I understand that the staff of this agency may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior citizen, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my therapy to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed.
3. I understand that my therapy may involve my participation in individual, couple, family, and/or group counseling, and may involve homework assignments for me to do outside of therapy sessions. I agree to participate actively in my therapy, to cooperate with my therapist, and to complete required homework assignments or other activities included in my therapy.
4. I understand that my therapy may include my attendance at meetings of independent self-help support groups including Alcoholics Anonymous, Narcotics Anonymous, and/or other programs. I agree to participate in such programs if assigned and to abide by the practices of those programs regarding protecting the privacy and anonymity of other program participants.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Telehealth Consent Form

Patient Name: (Print)_____

DOB: _____

Telehealth, according to the Centers for Medicare & Medicaid Services, is "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." There are multiple criteria (video face-to-face consultation, for example) for both patient and provider to fulfill in order for a consultation to be deemed an appropriate Telehealth visit.

We are requesting that People In Need patients acknowledge the following:

1. I understand that all federal and Pennsylvania state laws protecting the privacy and confidentiality of medical information also apply to telehealth
2. Video conferencing with your provider will be through the HIPAA compliant telemedicine service provider Doxy.me, LLC.
3. My healthcare provider has explained to me how the video conferencing technology will be used and that the visit may not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
5. I understand that my healthcare provider or I can discontinue the telehealth consult/visit and future telehealth visits at any time. I understand that withdrawal of my telehealth consent will not affect my future care nor treatment with this agency.
6. I understand that certain procedures such as psychological testing and medication management cannot be performed via telemedicine.
7. I understand my health care provider may feel the telehealth discussion may not be adequate and may request an actual visit to the office for more detailed consultation and examination.
8. You should contact your insurance agency regarding telehealth coverage by calling the phone number on your insurance card.

My Responsibilities:

1. I understand that I must be physically within Pennsylvania to be eligible for telehealth and that my healthcare provider can send prescriptions for medications only to Pennsylvania pharmacies or addresses.
2. I will not record any telehealth session without written consent from People In Need.
3. I consent to screen photos which include my name, picture, start and end times of session, and consent for my Treatment Plan. All of the above will remain confidential, protected health information.
4. I will inform my healthcare provider as soon as my session begins if there are any other surrounding people that are listening or watching the session. If there are surrounding people that will stay for the session, I am giving my consent for them to listen in on my health care.
5. I will notify my healthcare provider if there is any point in the consultation that my equipment fails and I am unable to have clear audio.

In signing my consent below, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date

_____ _____

Therapist/CRNP signature Date

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CONFIDENTIALITY IN THERAPY POLICY

Before you tell your therapist about yourself, you have the right to know what information can and cannot be kept confidential. Please read this so you can understand the conditions described. If there is anything you don't understand your therapist will explain it in more detail.

General Extent and Limits of Confidentiality

The laws and ethics governing therapy require that therapist keep all information about clients confidential except for certain types of information and situations.

Those exceptions are:

1. **Client's desire:** If you want your therapist or this agency to give information about your case to anyone outside this agency, you must sign a Release of Information giving written permission for this disclosure.
2. **Safety: (a) Risk of self-harm:** If your words or behavior convince your therapist that you are likely to harm yourself, either deliberately or because you are unable to keep yourself safe, your therapist must do whatever he or she can to prevent you from being harmed. This means the therapist must take action up to and including hospitalizing you with or without your consent. If this situation comes up, your therapist will discuss it with you before taking action unless it appears that this would be unsafe or immediate action is needed to keep you from being harmed.
   (b)Emergencies: In and emergency when your health or your life is endangered, your therapist must provide medical personnel or other professionals any information about you that is needed to protect your life, but only information that is needed for that purpose. If possible your therapist would discuss it with you and get your permission first. If not, he or she would talk with you about it afterward.
3. **Abuse:** If your therapist obtains information leading him or her to believe or suspect that someone is abusing a child, a senior citizen, or a disabled person, the therapist must report this to a state agency. "To abuse" means to neglect, hurt, or sexually molest another person. The therapist cannot investigate and decide whether abuse is taking place: if the suspicion is there, the therapist must report it. The state agency will investigate. If you are involved in a situation of this kind, you should discuss it with a lawyer before telling your therapist anything about it unless you are willing to have the therapist make such a report. If this situation comes up, your therapist will discuss it with you if possible before making a report.
4. **Therapy of children, families, and couples: (a) Children and Adolescents:** It is the policy of this agency, when a therapist treats children and adolescents, to ask their parents or guardians to agree that most details of what their children or adolescents tell the therapist will be treated as confidential. However, parents or guardians do have the right to general information about how therapy is going. The therapist may also have to tell parents or guardians about information if their children or others are in any danger. If this situation

comes up, the therapist will discuss it with the child or adolescent first before talking to the parents or guardians.

(b) Families: At the start of family therapy all participants must have a clear understanding of any limits on confidentiality that may exist. The family must also specify which member of the family must sign Release of Information forms if necessary for the records of family therapy.

(c) Couples: If one member of a couple tells a therapist something the other member does not know, and not knowing this could harm him or her, the therapist cannot promise to keep it confidential from the other person. If this occurs the therapist will discuss it with you before doing anything else.

5. **Professional Consultation:** Your therapist may consult with a clinical supervisor or another colleague about your treatment. The other therapist must give you the same confidentiality as your therapist. If this fellow therapist is employed at this agency, no written authorization from you is required. If your therapist discusses your case with a professional outside this agency, such as a therapist who treated you in the past, he or she must get your written permission (a Release of Information form) first. If another professional asks your therapist for information about you during or after your treatment, your therapist cannot provide any information unless that other professional provides a Release of Information which you have signed authorizing your therapist to provide that information.
6. **Legal Proceeding:** If a judge orders your therapist to provide information about your history or your treatment, the therapist must do so.
7. **Debt Collections:** If you fail to pay for services as agreed, and other methods of resolving the problem fail, this agency may have to use a collection agency or other legal means to collect the fees your owe. The only information the agency would disclose for this purpose would be your name, address, the dates of service, and the amount of your unpaid balance.
8. **Referring agencies and conditions of treatment:** If you have been involuntarily referred for treatment by a court or a government agency such as a probation department or Child Protective Services, your treatment may include requirements that you comply with conditions including reporting of information about your therapy to the agency that referred you for treatment, or reporting to that agency if you appear to have violated laws regarding substance abuse or agency rules regarding satisfactory participation in this program. If such reporting requirements exist, your therapist will tell you about them before you start therapy, and will notify you when making any such required reports.
9. **Independent disclosure by client:** Any information that you yourself share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

Signatures here show that we have read, understand, and agree to the conditions presented above.

Client Name: _____ Date: _____

Signature: _____

Parent/Guardian Name: _____ Date: _____

Signature: _____

Therapist Name: _____ Date: _____

Signature: _____

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PATIENT INFORMATION

This is a Private Mental Health Outpatient Clinic

Hours/Appointment:
Monday, Wednesday, Thursday and Friday, 8:30am – 4:30pm, Tuesday 8:30am – 7:00pm. Walk-in appointments will not be accepted. Emergency appointment times are available during business hours.

Attending Your Appointments:
All therapy clients who meet with the psychiatrist must also meet with their therapist at least once per month. This enables the therapist and the psychiatrist to communicate important information which may aid in your personal treatment plan.

Cancellation of Appointments:
A 48-hour cancellation notice is required for scheduled appointments that are not attended. We understand that emergencies can arise; the above policy is needed to ensure everyone under treatment has access to the necessary treatment. A reminder Text/Email/Call will be made approximately 48-hours prior to each scheduled appointment. You will receive a warning letter after you have missed two appointments. If you miss three consecutive appointments you may be discharged as a client. We reserve the appointment times for you. We have clients waiting for appointments; please do not miss your appointment without 48-hour notice. **Patients are responsible to keep the receptionist informed of any change in phone numbers, e-mail address, address, or insurance.**

Emergencies:
If immediate action is needed due to potential danger to self and/or others, **Call 911 or go to the nearest emergency room. You may also call the Crisis Line (724)652-9000 or the National Suicide & Crisis Lifeline 988.**

Medication Refills:
Medication Refills are NOT Emergency issues. Enough medication will be provided to last until the next appointment. Never allow your medications to drop below seven days' supply if you do not have an appointment within the week. Medication refills will not be authorized if patient has not been seen for a period exceeding six months.

Behavior in Clinic, Verbal or Telephonic Communication:
All patients and those who accompany them are expected to treat anyone affiliated with the agency or other patrons with respect and dignity. Those who do not comply will be asked not to return to our agency.

Patient Termination Policy:
Every effort will be made to help alleviate distress and improve functioning. There may be times when patients may feel frustrated due to symptoms and severity of illness. Under **no** circumstances will abuse (physical or verbal) be tolerated toward any staff member. Immediate discharge from services should be expected if abuse occurs.

Evaluation:
Please bring your insurance card to the first visit. An individualized treatment plan will be provided after a thorough evaluation. Follow-up appointments are usually scheduled within one month of the first visit depending on individual needs. Appointments can be made prior to the next scheduled visit if the need arises by calling the main office at (724)657-3303.

Fees:
Payment is due at each scheduled appointment. Please be aware of any co-payment amount or out of pocket expenses depending on your insurance. Our office accepts Cash, Check or Credit Cards. Please check with your individual insurance plans for details. Court ordered and self-pay patients will be assigned a fee due at time of service, unless a payment plan is authorized.

Insurance
Most insurance plans are accepted, including Medicare and Medicaid. It is the patient's responsibility to know what, if any amount(s) will be assessed to them. We will provide as much information as possible, but ultimately it is the insured's responsibility to be aware of his or her own coverage.

Weapons: Weapons of any kind are not permitted on these premises.

Children: Do not leave your child unattended while at our agency.

Appropriate Dress: Patients and those who accompany them are expected to wear appropriate clothing. Shirts and shoes are required; swimsuits are not acceptable.

I HAVE BEEN OFFERED A COPY OF THIS INFORMATION:

ACCEPT: ☐ DECLINE: ☐

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

People in Need
...the one stop center for social services

2703 West State Street, New Castle, PA 16101
Phone: 724-657-3303 Fax: 724-657-3326 www.pinpa.org

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the agency to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR-164.520©(2)(II), PART OF THE FEDERAL PRIVACY REGULATION FOR THE Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by People In Need, Inc. (the "Agency") for the purposes of treating me, obtaining payment for treatment of me and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Agency maintains a Privacy Notice which set forth the types of uses and discloses that the practice is permitted to make under the Privacy Regulations and set forth in detail the way in which the Agency will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Agency has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Agency at the following address:

   People In Need
   Attention: Practice Compliance Director
   2703 W. State Street
   New Castle, PA 16101

4. I understand and acknowledge that I have the right to request that the Agency restrict how my information is used and disclosed to carry out treatment, payment, or healthcare operation. I understand and acknowledge that the Agency is not required to agree to restriction requested by me, but if the Agency agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Agency's use and/or disclosure of my health information (leave blank if no restrictions).

_____

_____

_____

I understand the foregoing provision, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE AGENCY'S POLICY NOTICE AND AGREE TO THE AGENCY'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Patient's Date of Birth

_____

Patient's Social Security Number

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

_____

To Be Completed by the Agency

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____Accepted _____Denied _____Not Applicable

_____Other (explain) _____

_____ _____

Signature of Authorized Practice Representative Date

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Release and Assignment

I acknowledge that I was present to receive service(s) on this date at People In Need, Inc.

I authorize the release of any medical information necessary to process my insurance claim(s).

I authorize and request payment of medical benefits directly to the Provider.

I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me.

I agree that a photo copy of this form may be used in lieu of the original.

I understand that I am responsible for the full amount of my bill for services provided, including any deductible, co-pay, co-insurance, and/or any other balance not paid by my insurance.

By signing this form, I acknowledge that I have read and understand the above information and agree to all provisions.

Date: _____ **Time:** _____**AM / PM**

Patient Name: _____

Client Signature: _____