First Name:	Last Name:
Client ID:	Date of Birth:

CLIENTS' CHART TABLE OF CONTENTS

- Intake packet
    - Record of Access
    - New Client Checklist
    - Intake Face Sheet
    - Identification Cards
    - TMHP verification sheet
    - Copy of Insurance Card
    - Client Data
    - Medical History Questionnaire
    - Consent for Treatment
    - Client Rights and Responsibility
    - Notification of receipts or recipient rights
    - Privacy Notice Acknowledgement (HIPAA)
    - How to make a Complaint
    - Crisis Response
    - Rights to Appeal Process
    - Abuse and Neglect Procedure
    - Emergency preparedness questionnaire
    - Authorization for school visits
    - Client Orientation Checklist
    - Freedom of choice form
    - Consent to release or obtain information
        - ***School Information**
        - ***PCP Information**
        - ***Emergency Contact**
        - ***Social Service/ Foster Care Agencies**
- PA
- Assessment
    - **CANS**
    - **OTR**
    - **Diagnosis Sheet**
    - **Psychosocial Assessment**
- Treatment Plan
- Psych Evaluation
- Reauthorization
- Meds/Labs
- Fax Correspondence

***Consumer Satisfaction Survey - Intake and Screening**

First Name:	Last Name:
Client ID:	Date of Birth:

RECORD OF ACCESS

DATE	Reason for Access	Person Accessing Record	Title

First Name:	Last Name:
Client ID:	Date of Birth:

New Client Checklist

Enrollment Packet Completion Date: _____

- ☐ Intake Packet
  - Signed by client / legally responsible
  - Signed by CSC representative
  - Medicaid eligibility printout / Medicaid card
- ☐ CMBHS Diagnosis Sheet
- ☐ CMBHS CANS assessment printed and signed
- ☐ OTR
- ☐ Treatment Plan
  - Signed by LPHA
  - Signed by case worker
  - Signed by client/ Legally Responsible Person
- ☐ Mental Health Assessment
  - Signed by LPHA
- ☐ Forms to upload to client's profile:
  - CMBHS diagnosis Sheet
  - CMBHS CANS (closed and complete status)
  - OTR
  - Treatment Plan
  - Mental Health Assessment
- ☐ Sharenote
  - Assign Case Worker
  - Assign Services based on LOC
  - Confirm Treatment Plan is signed
  - Add PA units

FOLLOW UP CALL:

Date of call: _____ **Contact Person**: _____

Staff Name:_____ **Staff Title**: _____

COMMENTS: _____

Assigned Case Worker:_____**Date Assigned**: _____

Client Enrollment Completed by:_____**Date**: _____

First Name:	Last Name:
Client ID:	Date of Birth:

INTAKE FACE SHEET

Name: _____ Date: _____ Age _____

Height:_____Weight:_____Eye Color:_____

Insurance Company # _____ Medicaid # _____

_

Address_____ City/State/Zip _____

__

Home #_____Cell Phone #_____Work#_____

Employment Status: ☐ Part-time ☐ Full-time ☐Retired ☐ Unemployed ☐ Not in labor force
Employer: _____

Marital Status: ☐ Single ☐ 2.Married Gender: ☐ 1.Male ☐ 2.Female

Student Status: ☐ 1.Full Time Student ☐ 2.Part-time Student ☐ 3. Not a student

School_____Last Grade Completed: _____

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Other_____

Preferred Language:_____Need Interpreter YES / NO

Have you previously received or currently receiving mental health services? ☐ Yes or ☐ No If yes,

please list:_____

Primary Physician Name:_____Phone#_____Last seen:_____

Referred By_____

Reason for referral: _____

Legally Responsible Person_____Relationship _____

Address_____City/State/Zip _____

Phone #_____ Work Phone # _____

Emergency Contact Information

_____

Name Relationship Phone#

_____

Name Relationship Phone#

First Name:	Last Name:
Client ID:	Date of Birth:

Client Data Form
Presenting Problem(s)- Please check all that apply

_____Anxiety
_____Criminal behavior (stealing, vandalism, etc.)
_____Constant restlessness
_____Homicidal
_____Forgetfulness
_____Defiance/Oppositional
_____Destructiveness (destroying property)
_____Hurting animals (pets)
_____Change in appetite
_____Hallucinations (visual, auditory, etc.)
_____Obsessions/compulsions
_____Insomnia or Hypersomnia
_____Obsession with firearms
_____Fidgety
_____Fighting
_____Fire-setting
_____Cutting self
_____Disrespectfulness
_____Self-Injurious behaviors
_____Difficulty concentrating
_____Temper tantrums
_____Withdrawal/Isolation
_____Excessive energy
_____Violent/aggressive behaviors
_____Crying Spells
_____Phobias
_____Running away
_____Suicidal
_____Depression
_____Lying
_____Low-Self-esteem
_____Bullying
_____Hyperactive
_____Delusions
_____Excessive talking
_____Impulsiveness
_____Gravely impaired

If suicidal, homicidal, gravely impaired or need further clinical guidance contact a licensed clinician to further assess for triage! Document clinical disposition when applicable.

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
LMHP's Signature & Credentials Date

First Name:	Last Name:
Client ID:	Date of Birth:

MEDICAL HISTORY QUESTIONAIRE

1. Are you taking any **medications** (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)?

2. Identify the medications that you are currently taking for medical or behavioral health concerns, and the reason for take the medications, below:

Name of Medication	Dosage	Frequency	Duration	Prescriber

3. Are you **allergic** to any medications? □ NO □ YES – Which ones?

4. Do you have any other **allergies**? □ NO □ YES – Describe them.

5. Who is your primary care physician? When was the last time you saw your primary care physician and what was the purpose of that visit?

6. Are you currently **pregnant**? □ NO □ YES □ Unsure □ N/A

7. Are there any **medical problems** that you are currently receiving treatment for?
□ NO □ YES

8. Does your current medical condition(s) create problems in how you deal with life, including pain?
□ NO □ YES – Explain

_____ _____

Recipient or Legally Responsible Person / Date Agency Representative/ Date

First Name:	Last Name:
Client ID:	Date of Birth:

CONSENT FOR TREATMENT

In signing this document, I am stating that I have read and agree to the following conditions regarding services rendered by Uniquely You Behavioral Health Services:

1. I consent to and authorize treatment through Uniquely You Behavioral Health
2. I authorize the collection of necessary administrative dates regarding me. I understand that such data shall be computerized for statistical, programming, and billing purposes.
3. I understand information regarding me shall be collect responsibility and maintained in a confidential clinical record. Any such records or information shall remain confidential except in the following incidences:
   a. Information required by third party payers and parties giving UYBHS authorization to provide said services shall be forwarded to them.
   b. Records shall be open to Uniquely You Behavioral Health staff as needed and to appropriate state mental health officials.
   c. Information may be exchanged if I sign a written release form indicating the nature of information to be released.
   d. Information, which indicates a severe threat to the life or safety or another person or to self, shall be forwarded to the threatened parties or appropriate agencies to the extent necessary to protect life and safety.
   e. Information will be released if required under a court subpoena.
   f. Suspected abuse or neglect shall be reported to Protective Services as mandated by the Code of Texas and Federal Law.
   g. State and Federal law prohibits the disclosure of any information identifying a Recipient as receiving alcohol/drug services unless the Recipient consents in writing, the disclosure is allowed by court order, disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluations.
   h. Federal Law does not protect any information about a crime committed by a Recipient either at the program or against any person who works for the program or about any threat to commit such a crime.
4. I understand that all services will be provided regardless of gender, color, national origin, sexual orientation, religious preference, and a level of disability.
5. If there is a medical or psychiatric emergency, I give permission for staff to seek emergency care on my behalf.
6. Uniquely You Behavioral Health staff may share information with my consent with other associated facilities such as group homes, Dept. of Social Services, Court Services, and Area Programs if a Recipient is seen in two or more of these agencies.
7. I agree to satisfy my financial obligation with Uniquely You Behavioral Health. I understand payment is due at the time services are rendered unless payment arrangements are made.
8. You have the right to accept or refuse any medication, procedure test or treatment. Exception to this right is when there is an emergency, court order or if the recipient is under 18 years old and his/her parent or guardian has given permission.

I understand that I will be receiving the following services:

- ☐ Assessment/ Reassessment
- ☐ Skills Development and Training
- ☐ Individual /Family Intervention Counseling
- ☐ Other_____
- ☐ Medication Training and Support
- ☐ Intensive Case Mgmt
- ☐ Group
- ☐

_____ _____

Recipient or Legally Responsible Person / Date Agency Representative/Date

First Name:	Last Name:
Client ID:	Date of Birth:

CLIENT'S RIGHTS AND RESPONSIBILITIES

Uniquely You Behavioral Health's policy is to protect the rights of each client. During the intake process, the client's rights are reviewed in a manner that is understandable. The Corporate Compliance Officer responds to questions and grievances pertaining to the client's rights and ensures compliance with Texas administrative code. **Rule §404.154**. The client's rights and responsibilities are reviewed annually as listed below.

CLIENT RIGHTS:

1. To be informed of the client's rights and responsibilities at the time of admission or within 24 hours of admission;

2. To have a family member, chosen representative and/or his or her own physician notified of admission to the BHS provider at the request of the client;

3. To receive treatment and medical services without discrimination based on race, age, religion, national origin, gender, sexual orientation, or disability;

4. To maintain the personal dignity of each client;

5. To be free from abuse, neglect, exploitation and harassment;

6. To receive care in a safe setting;

7. To receive the services of a translator or interpreter, if applicable, to facilitate communication between the client and the staff

8. To be informed of the client's own health status and to participate in the development, implementation and updating of the client's treatment plan;

9. To make informed decisions regarding the client's care by the client or the client's parent or guardian, if applicable, in accordance with federal and state laws and regulations;

10. To participate or refuse to participate in experimental research when the client gives informed, written consent to such participation, or when a client's parent or legal guardian provides such consent, when applicable, in accordance with federal and state laws and regulations;

11. To be informed, in writing, of the policies and procedures for filing a grievance and their review and resolution;

12. To submit complaints or grievances without fear of reprisal;

13. To have the client's information and medical records, including all computerized medical information, kept confidential in accordance with federal and state statutes and rules/regulations;

14. To be given a copy of the program's rules and regulations upon admission;

15. To receive treatment in the least restrictive environment that meets the client's needs;

16. To not be restrained or secluded in violation of federal and state laws, rules and regulations;

17. To be informed in advance of all estimated charges and any limitations on the length of services at the time of admission or within 72 hours (There are no out of pocket fees associated with services provided to Medicaid recipient's)

18. To receive an explanation of treatment or rights while in treatment;

19. To be informed of the:

a. nature and purpose of any services rendered;
b. the title of personnel providing that service;
c. the risks, benefits, and side effects of all proposed treatment and medications;
d. the probable health and mental health consequences of refusing treatment; and
e. other available treatments which may be appropriate;

20. To accept or refuse all or part of treatment, unless prohibited by court order or a physician deems the client to be a danger to self or others or gravely disabled;

21. To have a copy of these rights, which includes the information to contact Uniquely You Behavioral Health located at:

UNIQUELY YOU BEHAVIORAL HEALTH SERVICES, LLC
9894 BISSONNET ST, STE 330 HOUSTON, TX 77036
P: 713-497-5344 F: 713-513-5439
EMAIL: info@uniquelyyoubhs.org

CLIENT RESPONSIBILITIES:

To make your mental health treatment successful, we need to work together. The agency asks that all clients provide clear, complete, and truthful information always. We do our part by providing you with information concerning your rights and the services we offer. Your part is to take responsibility for the following:

1. Follow agency rules, policies, and procedures.
2. Follow the steps described in this handbook if you wish to file a grievance or appeal with our agency.
3. Keep scheduled appointments and call to cancel or reschedule if you cannot make your scheduled appointment.
4. Ask questions when you do not understand or when you want more information.
5. Provide any information to your worker that is necessary for your treatment.
6. Participate actively to create goals that will help you in your recovery.
7. Follow the treatment plans that you and your providers have agreed upon.
8. Take medications as they are prescribed for you.
9. Tell your doctor if you are having unpleasant side effects from your medications, or if your medications do not seem to be working to help you feel better.
10. Seek out additional support services in the community.
11. Invite the people (family, friends, etc.) who will be helpful and supportive to you to be included in your treatment.
12. Understand your rights and the grievance process.
13. Treat staff, as you would expect to be treated.

First Name:	Last Name:
Client ID:	Date of Birth:

NOTIFICATION OF RECEIPT OF RECIPIENT RIGHTS

I understand its contents regarding Recipient rights and responsibilities. I have received a copy of the confidentiality notice, Recipient Handbook (which includes a summary of my rights), and Program Rules. I have also been explained the services, including the benefits and risks, program rules and grievance procedure. I also understand that I may withdraw from Uniquely You Behavioral Health anytime I feel treatment/services are not beneficial to me. Staff has answered my questions regarding Recipient rights.
I also understand that specific programs may have additional policies and procedures pertaining to Recipient rights and that those will be explained to me upon entry into the program.

I have received the following information:

1. Protections regarding disclosure of confidentiality;
2. Procedure for obtaining a copy of my treatment plan;
3. Policies addressing fee assessment and collection practices for my treatment rehabilitation;
4. Grievance policy/procedure;
5. Suspension and expulsion policy notification
6. Search and seizure policynotification;

Uniquely You Behavioral Health will implement the use of least restrictive intervention and most appropriate setting and methods as a last resort. Uniquely You Behavioral Health prohibits the contingent use of painful body contact, or substances administered to induce bodily painful reactions exclusive.

PRIVACY NOTICE ACKNOWLEDGMENT FORM (HIPAA)

I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Uniquely You Behavioral Health. I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint.

I may review a copy of the Notice from Uniquely You Behavioral Health office.

I may obtain a copy of this from Uniquely You Behavioral Health Services, LLC.

I understand that the terms of this Notice may be changed in the future, and these changes will be posted in Uniquely You Behavioral Health office. I may also request a copy of the new Notice by contacting the Privacy Officer.

HOW TO MAKE A COMPLAINT OR FILING A GRIEVANCE

If you are dissatisfied with the services being provided by Uniquely You Behavioral Health or if you wish to file a grievance against perceived unfair treatment, the follow procedures can be followed:

- Begin by explaining your concern, complaint, or grievance to the Professional providing the service.
- The treating professional will attempt to resolve the problem by scheduling a meeting to come to a joint decision.

First Name:	Last Name:
Client ID:	Date of Birth:

- If the contact with the professional does not resolve the problem, put your concern/grievance in writing and ask for it to be reviewed in the Client Rights Committee for resolution. This can be done so by completing a grievance form. Please feel free to ask a UYBH staff for the form. An appeal process will take place and a representative of the company will get back with you.
- If the management and client rights committee is unable to resolve the issue to your satisfaction, you can seek legal advice as necessary at you own expense.
- You can also contact the **Office of Consumer Services and Rights Protection at 1800- 252-8154**

CRISIS RESPONSE SERVICE

I have been informed that Uniquely You Behavioral Health has a crisis response line (713-497-5344) available 24hrs /7 days a week, 365 days a year for Recipient to use in crisis situations. A designated on-call qualified professional will be responsible for responding to all crisis calls during and after regular business hours. The on call qualified professional will be responsible for the implementation of Crisis Plan via phone and face to face within two hours. The on call qualified professional will have access to the crisis plan for everyone.

RIGHT OF DETERMINATION APPEAL PROCESS

UYBH will not deny, interrupt, suspend, reduce, or terminate your services without a good cause. If you are a Medicaid recipient (or eligible to be one) and a decision has been made to deny, reduce, suspend, or terminate services being received, then you have the right to appeal the decision.

A notification of the decision will be sent by your MCO. If you need clarifications on any issues, please contact Uniquely You Behavioral Health immediately. We will assist you with the appeal process follow up.

Recipients may be expelled or suspended from services when the agency can no longer meet the recipient's needs or guarantee their safety. Uniquely You Behavioral Health shall notify recipients once a specific time is determined to restore services. Uniquely You Behavioral Health shall make efforts to recommend appropriate services that will meet recipient's needs and discharge plan if any.

ABUSE / NEGLECT PROTOCOL / PROCEDURE

It is your right to be free of harm, abuse, neglect, and exploitation. Uniquely You Behavioral Health prohibits any abuse or neglectful conduct on the part of any individual employed or contracted by the agency or serving in a consultative capacity.

If for any reason, you have questions, concerns or complaints that involve any kind of abuse, sexual, physical etc. you should call the Texas Department of Family and Protective Service at 1-800- 252-5400

Recipient or Legally Responsible Person / Date **Agency Representative/ Date**

First Name:	Last Name:
Client ID:	Date of Birth:

EMERGENCY PREPARDNESS QUESTIONNAIRE

Please provide us with your updated emergency contact information and contact information of your evacuation destination.

EMERGENCY CONTACT:	ADDRESS:	PHONE:

Do you have somewhere to evacuate? **Yes** **No**
Do you plan to evacuate? **Yes** **No**

If so, when?
_____

Do you plan to return? **Yes** **No**
Who will evacuate with you?
_____
_____
_____
_____

Do you have the necessities to evacuate? **Yes** **No**
Do you currently own a cell phone? **Yes** **No**
If not, whom can we contact to reach you immediately
_____
_____

What is the best way to contact you? **Phone** **Text** **Email (**Circle All That Apply)
Any additional information/ comments:
_____
_____
_____
_____

_____ _____

Recipient or Legally Responsible Person / Date **Agency Representative/ Date**

First Name:	Last Name:
Client ID:	Date of Birth:

AUTHORIZATION FOR SCHOOL VISITS

I, _____Parent/Legally responsible person do give Uniquely You Behavioral Health Services staff the permission to visit my child at school to provide mental health rehabilitation services to my child.

Child Name	
School Name	
School Address	
School Phone Number	
School Counselor Name	
Grade:	
Teacher's' Name	

_____ _____

Recipient/ Legally Responsible Person **Date**

_____ _____

Agency Representative **Date**

First Name:	Last Name:
Client ID:	Date of Birth:

Client Orientation Checklist

Each client, parent, or legal guardian of a client will be instructed and given written information regarding the following, upon admission to Uniquely You Behavioral Health's program:

- Informed Consent/Freedom of Choice
- Non-discrimination provisions
- family involvement.
- safety.
- the rules governing individual conduct.
- authorization to provide treatment.
- adverse reactions to treatment.
- the general nature and goals of the program.
- proposed treatment to include treatment methodology, duration, goals, and services.
- risks and consequences of non-compliance.
- treatment alternatives.
- client's rights and responsibilities.
- all other pertinent information, including fees and consequences of non-payment of fees.

Additional information will be provided throughout the intake process, including but not limited to:

1. Grievance and Appeal Procedures
2. Communication/input policies regarding:
   a. Quality of Care
   b. Outcome Achievement
   c. Client Satisfaction
3. Explanation of the agency's
   - Mission/Philosophy/General nature and goals of the program
   - Services, activities, and therapeutic interventions
   - Family Participation/Involvement
   - Hours of Operation
   - 24-Hour on Call Policy
   - Code of Ethics
   - Confidentiality Policy and HIPAA Privacy Rights
   - Requirements for follow-up for mandated clients, regardless of his/her discharge outcome.
4. Explanation of all financial obligations, fees, and arrangements for services provided by the organization (There are no out of pocket fees associated with services provided to Medicaid recipient's).
5. Orientation with the agency facilities, including emergency exits, fire suppression equipment, and first aid kits.
6. The agency policies regarding safety and:
   a. Seclusion, restraints, or physical holds
   b. Smoking and Tabaco
   c. Illicit or licit drugs
   d. Weapons
   e. Abuse and neglect
7. Identification of direct care worker.
8. Program rules that identify:
   a. Any restrictions the program may place on clients.
   b. Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the client.
   c. Means by which the client may regain rights or privileges that have been restricted.

First Name:	Last Name:
Client ID:	Date of Birth:

9. Identification of the purpose and process of assessment.
    a. Smoking and Tabaco
    b. Illicit or licit drugs
    c. Weapons
    d. Abuse and neglect and exploitation

10. Program rules governing individual conduct, risk, and consequences of non-compliance.
11. Education regarding Advanced Directives, where appropriate.
12. Authorization to provide treatment and adverse reactions to treatment.
13. A description of how the Treatment Plan will be developed, treatment methodology, duration, goals, and services.
14. Information regarding transition, transfer and discharge criteria and procedures.
15. Treatment alternatives/Treatment approaches.
16. Non- payment fee, all clients must maintain Medicaid eligible to avoid disruption of services.
17. Health and Safety concerns inclusive of physical and Environmental safety, Waste Management, and Infection Control Factors.

By signing this acknowledgement, I agree to the terms of all contents of the Client Orientation/Intake Process and have received a copy of the Client Handbook.

_____ _____

Client/ Legally Responsible Person **Date**

_____ _____

Agency Representative Signature **Date**

First Name:	Last Name:
Client ID:	Date of Birth:

Member's Freedom of Choice Form

The provider I choose is:

Uniquely You Behavioral Health Services, LLC

By Signing below, I acknowledge that I freely choose to receive services from the above provider, and I acknowledge my responsibility to notify my previous provider to coordinate care.

MEMBER'S NAME	**MEMBER'S DATE OF BIRTH**
MEMBER'S LEGAL GUARDIAN (PRINT)	**MEMBER'S LEGAL GUARDIAN (SIGNATURE)**
MEMBER'S INSURANCE PROVIDER	**DATE**

This provider assumes responsibility of coordinating care with the prior provider record.

Agency Representative Signature: **Date:**

First Name:	Last Name:
Client ID:	Date of Birth:

CONSENT TO RELEASE OR OBTAIN INFORMATION

I, _____request and authorize	**Uniquely You Behavioral Health Services** **P: 713-497-5344 F: 713-513-5439** **EMAIL: info@uniquelyyoubhs.org** **9894 BISSONNET ST, STE 330** **HOUSTON, TX 77036**

to ☐ obtain healthcare information or ☐ release healthcare information of the recipient named above from/to:

Name: (**Primary Care Dr Information**)

Address:

City/State/ Zip:	**Phone**:	**Fax:**

This request and authorization applies to:

☐ All Healthcare information relating to the following treatment, condition, or dates:

☐ Clinical Evaluation	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Social History	☐ Medical History, Examination, Reports	☐ Discharge Summary
☐ Laboratory Results	☐ Quarterly Summary	☐ Treatment Plan
☐ Doctor's Progress Notes	☐ Pharmacy Notes	☐ Other _____

This consent is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This authorization shall expire on_____ (date or event). I understand that if I do not specify an expiration date/event, this authorization shall expire one year from the date of consent.

I understand that the treatment/services are not contingent upon my signing or not signing this authorization. I freely and voluntarily give my authorization for the release of information for my health records.

TO PARTIES RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations **(42 CFR, Part 2)** prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains. A general authorization for the release of health or other information is not sufficient for this purpose**.**

Recipient / Legally Responsible Person Signature:	Date Signed:
Agency Representative Signature:	Date Signed:

First Name:	Last Name:
Client ID:	Date of Birth:

CONSENT TO RELEASE OR OBTAIN INFORMATION

I_____request and authorize	**Uniquely You Behavioral Health Services** **P: 713-497-5344 F: 713-513-5439** **EMAIL: info@uniquelyyoubhs.org** **9894 BISSONNET ST, STE 330** **HOUSTON, TX 77036**

to ☐ obtain healthcare information or ☐ release healthcare information of the recipient named above from/to:

Name: (**Emergency contact Information**)

Address:

City/State/ Zip:	Phone:	Fax:

This request and authorization applies to:

☐ All Healthcare information relating to the following treatment, condition, or dates:

☐ Clinical Evaluation	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Social History	☐ Medical History, Examination, Reports	☐ Discharge Summary
☐ Laboratory Results	☐ Quarterly Summary	☐ Treatment Plan
☐ Doctor's Progress Notes	☐ Pharmacy Notes	☐ Other _____

This consent is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This authorization shall expire on_____ (date or event). I understand that if I do not specify an expiration date/event, this authorization shall expire one year from the date of consent.

I understand that the treatment/services are not contingent upon my signing or not signing this authorization. I freely and voluntarily give my authorization for the release of information from my health record. I also understand and authorize that this information may be sent via facsimile transmission.

TO PARTIES RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations **(42 CFR, Part 2)** prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains. A general authorization for the release of health or other information is not sufficient for this purpose**.**

Recipient / Legally Responsible Person Signature:	Date Signed:
Agency Representative Signature:	Date Signed:

First Name:	Last Name:
Client ID:	Date of Birth:

CONSENT TO RELEASE OR OBTAIN INFORMATION

I_____request and authorize	**Uniquely You Behavioral Health Services** **P: 713-497-5344 F: 713-513-5439** **EMAIL: info@uniquelyyoubhs.org** **9894 BISSONNET ST, STE 330** **HOUSTON, TX 77036**

to ☐ obtain healthcare information or ☐ release healthcare information of the recipient named above from/to:

Name: **(School Information)**

Address:

City/State/ Zip:	Phone:	Fax:

This request and authorization applies to:

☐ All Healthcare information relating to the following treatment, condition, or dates:

☐ Clinical Evaluation	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Social History	☐ Medical History, Examination, Reports	☐ Discharge Summary
☐ Laboratory Results	☐ Quarterly Summary	☐ Treatment Plan
☐ Doctor's Progress Notes	☐ Pharmacy Notes	☐ Other _____

This consent is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This authorization shall expire on_____ (date or event). I understand that if I do not specify an expiration date/event, this authorization shall expire one year from the date of consent.

I understand that the treatment/services are not contingent upon my signing or not signing this authorization. I freely and voluntarily give my authorization for the release of information from my health record. I also understand and authorize that this information may be sent via facsimile transmission.

TO PARTIES RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations **(42 CFR, Part 2)** prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains. A general authorization for the release of health or other information is not sufficient for this purpose**.**

Recipient / Legally Responsible Person Signature:	Date Signed:
Agency Representative Signature:	Date Signed:

First Name:	Last Name:
Client ID:	Date of Birth:

CONSENT TO RELEASE OR OBTAIN INFORMATION

I_____request and authorize	**Uniquely You Behavioral Health Services** **P: 713-497-5344 F: 713-513-5439** **EMAIL: info@uniquelyyoubhs.org** **9894 BISSONNET ST, STE 330** **HOUSTON, TX 77036**

to ☐ obtain healthcare information or ☐ release healthcare information of the recipient named above from/to:

Name: **(Social Service/Foster Care Agencies)**

Address:

City/State/ Zip:	Phone:	Fax:

This request and authorization applies to:

☐ All Healthcare information relating to the following treatment, condition, or dates:

☐ Clinical Evaluation	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Social History	☐ Medical History, Examination, Reports	☐ Discharge Summary
☐ Laboratory Results	☐ Quarterly Summary	☐ Treatment Plan
☐ Doctor's Progress Notes	☐ Pharmacy Notes	☐ Other _____

This consent is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This authorization shall expire on_____ (date or event). I understand that if I do not specify an expiration date/event, this authorization shall expire one year from the date of consent.

I understand that the treatment/services are not contingent upon my signing or not signing this authorization. I freely and voluntarily give my authorization for the release of information from my health record. I also understand and authorize that this information may be sent via facsimile transmission.

TO PARTIES RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations **(42 CFR, Part 2)** prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains. A general authorization for the release of health or other information is not sufficient for this purpose**.**

Recipient / Legally Responsible Person Signature:	Date Signed:
Agency Representative Signature:	Date Signed:

First Name:	Last Name:
Client ID:	Date of Birth:

Consumer Satisfaction Survey - Intake and Screening

Please complete the following survey regarding your service received from Uniquely You Behavioral Health. Please choose your answer using the scale from Strongly Disagree to Strongly Agree.

	Strongly Disagree	Disagree	Not Applicable	Agree	Strongly Agree
1. Safety of the agency location if applicable	o	o	o	o	o
2. Cleanliness of the agency if applicable	o	o	o	o	o
3. Ability of staff to put me at ease with the enrollment process	o	o	o	o	o
4. Courtesy of the person assisting	o	o	o	o	o
5. Time taken to get help with someone who could assist me	o	o	o	o	o
6. Knowledge of the staff handling the enrollment	o	o	o	o	o
7. Overall satisfaction with the first encounter with the agency	o	o	o	o	o
8. Effort Taken by staff to getting any problems resolved	o	o	o	o	o
9. Professionalism of the intake staff	o	o	o	o	o
10. Individual differences are respected	o	o	o	o	o
11. Time taken to get my questions answered	o	o	o	o	o
12. Ability of the staff to help me understand the goal and objectives of the services provided	o	o	o	o	o
13. Staff demonstration to explain legal and ethical aspects of client confidentiality	o	o	o	o	o
14. Interest of staff in learning about what I want from services offered	o	o	o	o	o
15. Overall satisfaction with the screening process	o	o	o	o	o
16. Based on your experience to date, what is the likelihood of you recommending this agency to others?	o	o	o	o	o
17. What is your overall assessment of the agency	o	o	o	o	o

First Name:	Last Name:
Client ID:	Date of Birth:

UNIQUELY YOU BEHAVIORAL HEALTH SERVICES, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact:

Uniquely You Behavioral Health Services, LLC

P: 713-497-5344 F: 713-513-5439

This notice describes how medical information about a recipient may be used and disclosed and how to gain access to the above information. Please review it carefully.

All information that is provided during the screening, admission, and treatment/rehabilitation process is considered confidential by the employees, interns, and volunteers of Comcare. We are required to protect the privacy of health information of a recipient, and the disclosure of protected health information will be governed by the Health Insurance Portability and Accountability Act of 1996, as well as any other applicable federal or state laws.

Exchange and use of protected health information between Uniquely You Behavioral Health staff and/or Uniquely You Behavioral Health programs for the purpose of treatment, payment, or healthcare operations will be permitted and based on “need to know” guidelines, and positional authority. For example:

- Information obtained about a recipient by a psychiatrist, therapist, case manager, nurse or other member of the treatment team will be recorded in recipient’s record and used to determine the course of treatment that should work best for the recipient.
- Treatment team members will also be expected to discuss recipient progress with treatment on a routine basis.
- Information about the services received will be submitted and processed by the billing department so that the Agency can be paid, or the recipient can be reimbursed.
- Recipient medical record may also be pulled for review by the Quality Improvement department in preparation for an audit or for other internal reviews to improve the quality and effectiveness of the services being provided.

Disclosure of protected health information outside of Uniquely You Behavioral Health is permitted when recipient or their legal representative signs a written authorization or gives verbal authorization in an emergency. Any authorization for disclosure may be revoked at any time, except to the extent that action has been taken in reliance on it.

Recipients have the right to request restriction of the disclosure of their health information, except

First Name:	Last Name:
Client ID:	Date of Birth:

when Uniquely You Behavioral Health is required to do so. Even without recipient specific consent, Uniquely You Behavioral Health may disclose information to someone outside of Uniquely You Behavioral Health(and in some cases Uniquely You Behavioral Health may even be required by law or professional ethics to disclose recipient information), in the following situations:

- When there is a medical or psychiatric emergency involving recipient health or safety or safety of others.
- When Uniquely You Behavioral Health is required by law to report instances of neglect or abuse of a child or disabled adult.
- Disclosure in a legal proceeding, where Uniquely You Behavioral Health is responding to an order of a court or administrative tribunal.
- When Uniquely You Behavioral Health is required by Texas Administrative Code to disclose to the physician, information due to an incident which would cause health risk to other persons.
- When Uniquely You Behavioral Health authorizes research for the purpose of program planning and evaluation of services using statistical information that cannot be linked to the recipient as an individual.

Recipients also have other rights related to the use and disclosure of health information in their medical record. These rights include:

Right to request recipient medical record be designated as secured.
All medical records are secure and confidential. Recipient may restrict the disclosure of their medical records only for the purpose of treatment, payment, or healthcare operations. Uniquely You Behavioral Health will make every effort to accommodate recipient request, but we are not required to do so. For example, if the information is the subject of a lawsuit or legal claim or if release of the information may present a danger to you or someone else.

Right to inspect and request a copy of recipient medical record.
If recipients would like to inspect or receive a copy of their health information, please contact Uniquely You Behavioral Health for instructions on how to submit a written request. The agency may deny recipient request in limited circumstances. If request is denied, Uniquely You Behavioral Health will respond to the recipient in writing, stating why the request was not granted and describing any rights to request a review for denial. If recipient request is approved, the agency may charge a reasonable fee for the costs of copying, mailing or other supplies associated with any request for copies.

Right to request amendment of any section of recipient medical record.
If recipients feel that the agency has information that is inaccurate or incomplete, recipients have the right to request amendments of record. If request is denied, the agency will notify recipient in writing of the reason and will describe recipient rights to provide a written statement disagreeing with the denial.

Right to receive an accounting of disclosures that have occurred.
Each disclosure of protected health information will be documented in the medical record. Recipients have the right to request an accounting of the disclosures of previous years, if any.

Right to request an alternative method of contact.
Uniquely You Behavioral Health may call recipients or mail information regarding appointment reminders, billing information, or other information about treatment alternatives or services that might be of interest.

First Name:	Last Name:
Client ID:	Date of Birth:

If recipients would like to request an alternative method of contact, please notify the agency. Uniquely You Behavioral Health will accommodate reasonable requests, but may condition our accommodation on recipients providing, information regarding how payment, if any, will be handled.

Right to a copy of this Notice.
Recipients have the right to receive a paper copy of this Notice. Uniquely You Behavioral Health reserves the right to change this notice and to make the new notice effective for all protected health information that is maintained in hard copy or electronic format. Revisions to the **NOTICE OF PRIVACY PRACTICES** will be made available at each facility for distribution to all recipients.

Uniquely You Behavioral Health recognizes the importance of confidentiality, and recipient's right to be fully informed of all regulations regarding protected health information.

If recipients feel that their privacy rights have been violated, they may contact:

Uniquely You Behavioral Health Services, LLC
P: 713-497-5344 F: 713-513-5439
info@uniquelyyoubhs.org

CEO
Rockel Duff: rduff@uniquelyyoubehavioral.org

OPERATIONAL MANAGER
Brittany Mickey: bmickey@uniquelyyoubehavioral.org

OFFICE ADMIN
Jasamine Houston: jhouston@uniquelyyoubehavioral.org

OFFICE RECEPTIONIST
Latea Schnyder: lschynder@uniquelyyoubehavioral.org

OR

Office of Consumer Services and Rights Protection
Phone: (800) 252.8154
Fax:(512) 706-7353

1106 Clayton Lane
Austin, Texas 78723
Mail Code: H700

OR

Texas Department of Family and Protective Service
Call: 1-800-252-5400
If you cannot use the Texas Abuse Hotline you can. Report online a
www.TxAbuseHotline.org*External Link*

Provision of services will not be affected by the filing of any complaint.