Client Name: _____

Date of Intake Assessment: _____

Location:

☐ **El Reno** ☐ **Mid-Del** ☐ **Mustang** ☐ **Yukon**

Bridges of OKFCC
INTAKE FORMS PACKET
Outpatient pages 1-19 & 27-28
Partial Hospitalization Program please fill out all pages

Instructions:

Please read and sign all forms prior to meeting with your therapist. If you have any questions regarding the forms please speak with your therapist about them during your assessment session. It is mandatory that all forms in this packet are filled in completely and are signed & dated.

Bridges of OKFCC
CLIENT INFORMATION
(Please Print)

Client Name (First, MI, Last): _____

Client's SS #: _____ Sex: ☐ M ☐F Age: _____ DOB: _____

Client's Race/Ethnicity: ☐Caucasian ☐African American ☐Native American ☐Asian ☐Hispanic/Latino

☐Other _____

Responsible Party/Legal Guardian: _____

Relationship to the client: _____

Custody Status: ☐DHS ☐OJA ☐ Power of Attorney ☐Custodial Parent- ☐Mother ☐Father

☐Other: _____

Does the client have an advanced directive? ☐Yes ☐No If yes, please provide a copy before beginning services.

For OJA & DHS Custody: Primary Worker/Probation Officer: _____

Office Phone: _____ Fax: _____ Cell: _____

County: _____ Supervisor: _____ Email: _____

Is the parent/guardian active military? _____ What branch? _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Street Address: _____ City: _____ State: ___ Zip Code: _____

Client (or responsible party) Employed By: _____

Spouse's Name: _____ Spouse's Employer: _____

Primary Insurance: _____ Insurance #: _____

Secondary Insurance: _____ Insurance #: _____

Referred by: ☐ Self ☐ School ☐ Other _____ In case of an emergency, who should be notified? _____

Phone: _____ Relationship: _____

Total Family Income (Yearly): _____ Total Number Living in Household: _____

Names and ages of all household members: _____

_____

Please list your preferred pharmacy:

Pharmacy Name:_____ Phone Number:_____

Pharmacy Address: _____ City:_____Zip:_____

Bridges of OKFCC
RELEASE OF INFORMATION

I authorize the release of all or part of the Client's medical record, for this period of care, to any person or corporation liable for and part of the physician charges. State law requires that we advise: "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus, and Acquired Immunodeficiency Syndrome (AIDs)."

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Bridges of OKFCC to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Client signature: _____ ☐N/A, Minor Client Date: _____

Parent/Guardian: _____ Relationship to Client: _____

Date: _____

Bridges of OKFCC
POLICIES AND PROCEDURES

Appointments
If you must cancel an appointment you have scheduled, please call immediately. Except under emergency circumstances, 24 hours notice should be given for a cancellation.

Confidentiality
Your privacy is of utmost importance. It is strongly recommended that you review our *HIPPA Privacy Notice* for important details regarding the policies for maintaining confidentiality. In particular, you should be aware that you will only be contacted via means that you have specifically authorized in your new client paperwork. If you would like for information to be exchanged with persons other than yourself, an *Authorization for Release of Information* for must be completed. This form is available upon request.

Services for teenagers and their families require special consideration with regard to privacy. It is important to know that the law dictates that parents have the right to examine their child's records (unless we determine that doing so would have a detrimental effect on the therapeutic relationship or the child's physical or psychological well-being). Privacy is essential to effective therapy for teenagers; therefore, the policy is to provide parents with general information regarding the progress of treatment. Additional information will not be provided to parents unless the child consents or is in danger of harming themselves or others.

Payment
OKFCC does not turn away Partial Hospitalization clients for inability to pay. We are contracted with the Oklahoma Health Care Authority to accept SoonerCare (Oklahoma Medicaid), and we can also make private pay arrangements. In addition, each program has a limited number of scholarships available for clients who do not have Medicaid and are unable to pay privately. Please inquire with the Program Director for more information.

Private Health Insurance
While we are able to attempt to file a claim with your private health insurance, please also be advised that many health insurance plans have limited to no coverage for behavioral services (specifically Partial Hospitalization). In some cases, self-insured companies offer their employees coverage for behavioral services. We recommend that you contact your insurance company to discuss your coverage.

Termination of Services
Services may be terminated if it is determined that continued participation will be a detriment to your child or family. Your child's therapist, Program Director, and other members of the Treatment Team will discuss the best course of action for your family prior to terminating services or recommending a different course of treatment.

Client signature: _____ ☐N/A, Minor Client Date: _____

Parent/Guardian: _____ Relationship to Client: _____

Date: _____

Bridges of OKFCC FINANCIAL POLICY CONTRACT
ASSIGNMENT OF BENEFITS

Client _____ DOB _____

Thank you for choosing us as your behavioral health care provider.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Insurance Authorization and Assignment of Benefits

I hereby authorize Bridges of OKFCC & Dr. Al-Botros to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician / agency all payments for medical and behavioral health services rendered to me or my dependents. I further authorize assignment and payment directly to Oklahoma Family Counseling Centers, LLC, from insurance benefits and medical benefits due me.

Client/Parent/Guardian /Guarantor: _____ Date: ____/____/_____

Medicare/Medicaid Certification

I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare / Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits to Oklahoma Family Counseling Centers, LLC, for services rendered me.

Client/Parent /Guardian /Guarantor: _____Date: ____/____/_____

Relationship to Client (If Minor): _____

CONFIDENTIALITY OF CLIENT RECORDS

Client records and clinical information are confidential and are protected under the provisions of 43A O.S. Paragraph 3-422 and 3-423; and [U.S.] 42 CFR, Part 2. OKFCC has procedures protecting this confidentiality (and are communicated to the client for clients who have not been referred from the criminal justice system), which shall include, but not be limited to:

1. Medical records and all communications between client and doctor or psychotherapist are privileged and confidential; with such information limited to persons/agencies actively engaged in treatment or related administrative tasks.

2. Privileged/confidential information shall not be released to any person or entity not involved in the client's treatment without the written, informed consent of the client, or his/her guardian, or parent of a minor child, or a private or public childcare agency having legal custody of the minor child.

3. Identifying data may be released without the consent when:

   A. It is required to fulfill any statutorily required reporting of child abuse (10 O.S., Paragraph 7005) (1.7) and abuse of elderly incapacitated adults (43A O.S. Paragraph 10-104); or,

B. As provided by 10 O.S. Paragraphs 7005 (1.1) through (1.3); or,

C. On the order of a court or competent jurisdiction, or;

4. Restricting personal access of present or former clients to their records in a manner conforming to 43A O.S. Paragraph 1-109 (B). Records are kept for the benefit of clients, and therefore clients are provided access to records and copies of records, when requested in writing by competent clients, unless the records contain information that may be misleading or detrimental to the client. In situations involving multiple clients, access to records is limited to those parts of records that do not include confidential information related to another client.

5. With the consent of the client, providing information to responsible family members as provided and limited in 43A O.S. Paragraph 1-109 (C) (1.5).

6. The review of records by state or federal accrediting, certifying, or funding agencies may occur to verify services and or facility compliance with statutes and/or regulations.

CONFIDENTIALITY RIGHTS

Individuals have the right to have their records treated in a confidential manner within 42 CFR part 2 and HIPAA regulations. The confidentiality of client records maintained by the program is protected by Federal law and regulations. Generally, the program may not say to a person outside that program that a client attends the program or disclose any information identifying a client unless:

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

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulation.

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

Federal law and regulations ***do not*** protect any information about suspected child abuse or neglect form being reported under state law to appropriate state or local authorities.

Federal law and regulations ***do not*** protect any information about suspected adult/elder abuse or neglect form being reported under state law to appropriate state or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR Part 2 for federal regulations. Approved by the Office of Management and Budget under Control No. 0930-0099).

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Oklahoma Family Counseling Centers is committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective May 2003, and applies to all protected mental health information as defined by federal regulations. Your confidential protected health information will not be released without your written informed consent, except as otherwise permitted by Federal law: 42 CFR Part 2 §164.501 - §164.532 and Oklahoma Statute: Title 43a 1-109.

Understanding Your Mental Health Record/Information

Each time you visit a Oklahoma Family Counseling Centers' facility, a record of your visit is made. Typically, this record contains your presenting problems, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your case record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many mental health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer (Medicaid) can verify that services billed were actually provided,
- A tool in educating mental health professionals,
- A source of data for medical research (OKFCC does not participate in Medical research),
- A source of information for public health officials charged with improving the mental health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your case record and how your mental health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your case record is the physical property of Oklahoma Family Counseling Centers, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your case record as provided for in 45 CFR 164.524,
- Amend your case record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your mental health information as provided in 45 C:FR 164.528,
- Request communications of your mental health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose, mental health information except to the extent that action has already been taken.

OKFCC Responsibilities

Oklahoma Family Counseling Centers is required to:

- Maintain the privacy of your mental health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests yon may have to communicate mental health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your mental health information without your authorization except as described in this notice.

We will also discontinue using or disclosing your mental health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Oklahoma Family Counseling Centers' Chief Administrative Officer at (405) 265-3444.

If you believe your privacy rights have been violated you can file a complaint with Oklahoma Family Counseling Centers Chief Administrative Officer or with your Program Office for Civil Rights, U-S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.
For example: Information obtained by a nurse, physician, counselor or other member of your mental health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from our Partial Hospitalization program.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer (Medicaid). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and treatment procedures used.

We will use your health information for regular mental health operations.
For example: We will share your relevant mental health information with other providers involved in your care, to assist in the coordination of your care. This may include psychiatrists, physicians, psychologists, licensed counselors, psychiatric hospitals, or licensed mental health organizations prior to or after us who have provided you with mental health care.

Special use of your health information

Business associates: There are some services provided in our organization through contacts with business associates. Examples include pharmacy services, physician services, psychological services and consultant services. When these services are contracted, we may disclose your mental health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer (Medicaid) for services rendered. To protect your mental health information, however, we require the business associate to appropriately safeguard your information. Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general conditions.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, mental health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund Raising: OKFCC does not engage in fund-raising and you will not be contacted as part of any effort by OKFCC regarding fund-raising.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid court order from a judge.

Federal law makes provision for your health information to be released to an appropriate mental health oversight agency, public mental health authority or attorney, provided that a workforce member or business associate believes in good faith

that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more of persons served, staff or the public.

This notice of privacy practices applies to the following organizations:

Oklahoma Family Counseling Centers, LLC

Bridges of Yukon

Bridges of Mustang (Bronco Academy)

Bridges of El Reno

Bridges of Mid-Del

Dr. Adonis Al-Botros

Bridges of OKFCC
CLIENT RIGHTS

OKFCC & Dr. Al-Botros will be responsible for ensuring the implementation and maintenance of the client rights activities for all clients participating in organization services and other activities. Client Rights will be communicated to clients in a manner that is meaningful.

CLIENT RIGHTS

You have the right to a comprehensive copy of your "Client's Rights" as set forth in accordance with the Oklahoma Department of Mental Health and Substance Abuse Services. For your comprehensive copy please ask the Administrative Assistant or call (405) 577-5477 to request your copy. Thank You.

COMMUNICATION OF CLIENT RIGHTS

Clients' Rights are posted in all OKFCC administrative offices and clinics. As a routine part of the initial interview process, each client(s) will receive a copy of his/her/their rights and have them explained to him/her/them in language that is understandable. If the client's primary language is other than English, a copy of the clients' rights will be provided in the native language (to the extent possible). Documentation that these rights have been received and explained is to be indicated by the client signature on the client orientation checklist

CLIENT RIGHTS

ALL PERSONS RECEIVING SERVICES FROM OKFCC SHALL RETAIN AND ENJOY ALL CONSTITUTIONAL, STATUTORY RIGHTS, BENEFITS AND PRIVILEGES GUARANTEED TO ALL CITIZENS OF THE STATE OF OKLAHOMA AND THE UNITED STATES OF AMERICA, EXCEPT THOSE SPECIFICALLY LOST THROUGH DUE PROCESS BY A COURT OF LAW. IN ADDITION, ALL PERSONS SHALL HAVE THE RIGHT GUARANTEED BY THE SUBSTANCE ABUSE CLIENT'S BILL OF RIGHTS, UNLESS AN EXCEPTION IS SPECIFICALLY AUTHORIZED BY THESE STANDARDS OR AN ORDER OF A COURT OF COMPETENT JURISDICTION. EACH CLIENT SHALL BE NOTIFIED OF THESE GUARANTEED RIGHTS AT ADMISSION. SHOULD THE CLIENT BE A MINOR, HIS/HER PARENT OR LEGAL GUARDIAN, INCLUDING COURT ORDERED GUARDIANS, SHALL ALSO BE INFORMED. IF THE CLIENT CANNOT UNDERSTAND THE LANGUAGE IN THE BILL OF RIGHTS, AN ORAL EXPLANATION SHALL BE GIVEN IN A LANGUAGE THAT THE PERSON CAN UNDERSTAND. EACH PERSON SERVED BY OKFCC CAN EXPECT:

1. To be treated with respect and dignity. All OKFCC personnel are expected to perform all services in a manner that protects, promotes, and respects individual human dignity.

2. The right to a safe, sanitary and humane treatment environment.

3. The right to a humane psychological environment that protects him/her from harm, abuse, neglect, and/or exploitation.

4. To be provided services in an environment which provides reasonable privacy, promotes personal dignity, and provides the opportunity for improved functioning.

5. To be afforded the opportunity to participate in the treatment planning, and receive information regarding the treatment to be provided in order for informed consent, or refusal of consent, to be given to the proposed treatment. This shall stand unless a court of competent jurisdiction or, in emergency situations as defined by law, abridges the rights of the client.

6. The right to receive service(s) and/or appropriate referral suited to his/her conditions and needs without regard for race, color, age, gender, marital status, sexual orientation, religion, spiritual values, ethnic origin, co- occurring disorder, degree of disability, handicapping condition, legal status, and/or the ability to pay for the services.

7. To never be neglected and/or sexually, physically, verbally or otherwise abused, harassed, humiliated or punished.

8. The right to be provided with prompt, competent, appropriate services and an individual treatment plan.

9. The right to permit family members or significant others to be involved in their treatment and treatment planning.

10. The right to not be subjected to unnecessary, inappropriate, or unsafe termination from treatment. Discharge shall not take place as punishment for displaying symptoms of the client's disorder.

11. The right to have their records treated in a confidential manner within 42 CFR part 2 and HIPAA regulations.

12. The right to review their records according to the policies and procedures set forth by OKFCC that are in accordance with State and Federal laws including 42 CFR part 2 and HIPAA regulations.

13. The right to refuse to participate in any research project or medical experiment without specific informed consent as defined by law and that such refusal shall not affect the services available to the person served.

14. The right to request the opinion of an outside medical or psychiatric consultant, at the expense of the person served; and/or to request an internal facility consultation at no cost.

15. The right to assert grievances with respect to any alleged infringement of these stated rights or any other statutorily granted rights.

16. The right to never be retaliated against, or subject to any adverse conditions or treatment services solely or partially because of having asserted any of the person served rights listed in this document.

17. The right to mechanisms that will facilitate access and/or referrals to legal services, advocacy services, self-help groups, guardians and conservators.

18. The right to be informed that services can be refused and that there could be consequences to refusal of services.

19. The right to an expression of choice of release of information.

20. The right of choice of concurrent services.

21. The right of choice of composition of treatment team.

OKFCC's policy is to train all staff, contract employees, students, and volunteers in these rights and to insist on their observance as part of staff's program specific orientation. OKFCC policy and procedure is to ensure each client enjoys these rights and has explained to him/her these rights. These rights are visibly posted in public areas of the facility.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

CODE OF ETHICS

OKFCC Code of Ethics Preamble

OKFCC is a professional organization whose employees are dedicated to the enhancement of human development throughout the life span. OKFCC employees recognize diversity in our society and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of each individual.

The specification of a code of ethics enables OKFCC to clarify to current and future employees and to those served by the agency, the nature of the ethical responsibilities held in common by its employees. As the code of ethics of OKFCC is required to adhere to the Code of Ethics and the Standards of Practice. The Code of Ethics will serve as the basis for processing ethical complaints initiated against employees of OKFCC. Where applicable, the word counselor is to mean any and all employees.

OKFCC Code of Ethics

OKFCC therapists hereby affirm that…

OKFCC and OKFCC therapists' primary goal is to respect the dignity and promote the recovery of each client/consumer and his/her family. OKFCC therapists have a total commitment to provide the highest quality care for those who seek services from Oklahoma Family Counseling Centers.

OKFCC therapists shall present a genuine interest in all client/consumers and families and hereby dedicates themselves to the best interest of the client/consumers and to helping them to help themselves.

OKFCC therapists shall maintain at all times an objective, non-possessive, professional relationship with all clients.

OKFCC therapists shall be willing to recognize when it is in the best interest of the client/consumers to release them or refer them to another program or individual.

OKFCC therapists shall adhere to all the professional rules of confidentiality of all maintenance and distributions of records, material, and knowledge concerning the client and respect the integrity and protect the welfare of the person or group with whom OKFCC therapists work.

OKFCC therapists shall not in any way discriminate between client/consumers, families, or fellow professionals based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

OKFCC therapists shall maintain respect for the agency's policies and management functions, but will take the initiative toward improving such policies when it will better serve the interest of the client/consumers.

OKFCC therapists have a commitment to assess their own personal strengths, limitations, biases, and effectiveness on a continuing basis; that they shall continuously strive for self-improvement; and OKFCC therapists have a personal responsibility for professional growth through further education and training.

OKFCC therapists shall not have any type of outside involvement, including sexual intimacies, with client/consumers and shall not counsel persons with whom they have had a personal relationship.

OKFCC therapists shall be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. OKFCC therapists shall inform client/consumers when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that will protect the client/consumers' interest.

OKFCC therapists shall respect client/consumers' right to privacy. OKFCC therapists shall not solicit private information unless it is essential to providing service. Once private information is shared, standards of confidentiality apply.

OKFCC therapists shall not use derogatory language in written or verbal communications to or about client/consumers.

When OKFCC therapists act on behalf of client/consumers who lack the capacity to make informed decisions, OKFCC therapists shall take reasonable steps to safeguard the interests and rights of those client/consumers.

OKFCC therapists shall respect confidential information shared by colleagues in the course of their professional relationships and transactions.

OKFCC therapists shall advocate for adequate resources to meet client/consumers' needs.

OKFCC therapists shall be a diligent stewards of agency resources and therapists shall wisely conserve funds where appropriate and never misappropriate funds for unintended purposes.

OKFCC therapists shall not participate in, condone, or be associated with dishonesty, fraud, deception, or conduct that could affect the client/consumer relationship or the relationship of OKFCC with the community.

OKFCC therapists have a responsibility to themselves, their client/consumers, the community and associates to maintain their physical and mental well-being and shall adopt a personal and professional stance which promotes the well-being of all human beings.

(OKFCC) has utilized the National Counselors Code of Ethics as a base for this document.)

INPUT FROM PERSONS SERVED
CLIENT SATISFACTION - QUALITY OF CARE - OUTCOMES MANAGEMENT

Oklahoma Family Counseling Centers is a private, for-profit mental health provider dedicated to assisting Oklahoma families in improving their quality of life. We are dedicated to providing quality affordable and accessible mental health treatment. Treatment consists of a full continuum of services from education, prevention, treatment, and aftercare. Every individual deserves the opportunity to reach his or her highest potential with the best quality of life that is possible. This philosophy applies to all individuals served by OKFCC. This philosophy motivates OKFCC to provide quality behavioral health services to all consumers. These services are designed to support them and reduce their emotional stress in their later years.

OKFCC has an organized system to continuously obtain and review information from those OKFCC serves regarding the *Quality of Care* they received. This includes but is not limited to clients, family members, the school districts we serve, and other referral sources. OKFCC strives for continued improvement of its services to clients and the community. Input from persons served is the key component in OKFCC *Outcomes Management* process as it is the primary measure of client '*Satisfaction*' with OKFCC services. OKFCC uses the input to identify trends (either positive or negative) that impact the quality of care to clients and the community in an effort to continually improve the services provided.

CLIENTS/FAMILIES

A. Input from clients and families is collected by the Management Team or designee using a Client Satisfaction Survey at several points throughout a client's time with us. This includes but is not limited to admit (following the intake process), at various points during the treatment process, and transition/discharge. Participation in the Client Satisfaction Survey is not required but is encouraged. Surveys are anonymous, unless the client prefers to identify him/her self.

B. At a minimum, surveys include, but are not limited to:

1. Methods by which the former client may contact OKFCC for assistance concerning additional services and customer satisfaction.

2. Client satisfaction in the type of therapy they received and whether their problems had been addressed appropriately.

C. Clients may contact the agency administration anytime by accessing the OKFCC web-site: www.okfcc.org and clicking on "locations."

STAKEHOLDERS AND REFERRAL SOURCES

A. Input from stakeholders and referral sources will be sought a minimum twice per year. Program Directors will send community members, school contacts, and other referral sources a satisfaction survey to ensure we are providing the community with the highest possible quality of care.

Bridges of OKFCC
CONSENT FOR TREATMENT

Client Name: _____ DOB: _____

Benefits of Treatment:
Treatment can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems such as; anxiety, anger, depression, parenting or relationship concerns. Treatment can help a person develop new skills and to change behavior patterns. Treatment can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others.

Risks of Treatment:
I acknowledge that OKFCC has advised me and my child that while there are potential benefits to treatment, there is no guarantee of success and that there are potential risks. I have been advised that during treatment emotions and memories may be stimulated which can evoke strong feelings and that changes in awareness may alter self-perceptions and ways of relating to others. I have been advised that personal change can be quite varied and individual.
I understand that it is important to mention any concerns or questions that I have at any time during the process of treatment.

Services:
I understand that services provided, and that may be deemed necessary or appropriate by OKFCC Clinical Staff, include:

- Psychiatric Evaluations
- Individual Therapy
- Group Therapy
- Family Therapy
- Group Rehabilitation Services
- Individual Rehabilitation Services
- Other treatment as deemed necessary or appropriate

Consent:
In knowledge and appreciation of the benefits and risks as made known to me by OKFCC, and as reflected in this form, I hereby give my consent for my child to participate in treatment.

Confidentiality and Limits of Confidentiality:
I have been advised that all communications and records relating to treatment services are confidential and may not be disclosed without my written consent. I have also been advised that the law places certain limits on the confidential nature of the treatment services provided to me. I have been advised that these limits on confidentiality may arise if it is perceived that there is risk of harm in situations such as the following:

- if my child or I present an imminent danger to myself or others the law requires that steps be taken to prevent such harm;
- if a child is in need of protection a report must be filed with the appropriate agency or authority;
- if a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency;
- or if a court orders the disclosure of records

Acknowledgment and Consent:

I _____ acknowledge that I have had the opportunity to carefully read this document to ask, and have answered any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document, that it records my consent for treatment of myself and/or my child, and I have been given the opportunity to request a copy of it this _____ day of _____, 20___.

Client signature: _____ ☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date: _____

Bridges of OKFCC
LETTER OF TERMINATION

Client Name:_____ DOB: _____

☐ **This client is receiving mental health treatment services with another Provider/Agency and I wish to discontinue services.**

_____

(Individual, Agency, or Organization) (Phone Number)

_____

(Address) (City, State, Zip) (Fax Number)

Date of last visit with outpatient provider: _____ ☐ **N/A**

Frequency of visits with outpatient provider: _____ ☐ **N/A**

OR

☐ **Not Applicable – My child is not currently receiving any mental health treatment from another Provider/Agency**.

I will begin receiving services from Oklahoma Family Counseling Centers as of: _____
MM/DD/YYYY

Client signature: _____ ☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date: _____

Bridges of OKFCC
Self Report/Parent or Guardian Observations

Please circle/mark the answer(s) that best describes you (the client). Parents/guardians, please circle or mark your observations if the child is unable to fill in for themselves. Use the comments sections for any additional information.

	Never	Rarely	Sometimes	Frequently	Always
Anxiety	1	2	3	4	5
Comments: _____					
Depression	1	2	3	4	5
Comments: _____					
Hopelessness	1	2	3	4	5
Comments: _____					

Grief/Loses ☐ Years ago ☐ Months ago ☐ Past week ☐ Today
Comments: _____

Self Abusive Behaviors ☐ Cutting ☐ Burning ☐ Head banging ☐ Other: _____
Comments: _____

Suicidal Thoughts ☐ None ☐ Monthly ☐ Weekly ☐ Daily ☐ Currently
Comments: _____

Suicidal Plan ☐ No plan ☐ Unclear plan ☐Some plan ☐Well thought out
Comments: _____

Previous Suicide Attempts ☐ None ☐ History of (Please describe and give approximate dates in comments)
Comments: _____

Homicidal/Violent Thoughts ☐ None ☐ Monthly ☐ Weekly ☐ Daily ☐ Currently
Comments: _____

Homicidal/Violent Plan ☐ No plan ☐ Unclear plan ☐Some plan ☐Well thought out
Comments: _____

Hostility/Aggressiveness ☐ Verbal ☐ Property ☐ Towards Others ☐ Physical (Acting hostile/aggressive w/o harm)
Comments: _____

History of Violence ☐ Verbal ☐ Property ☐ Towards Others ☐ Physical (Acting hostile/aggressive w/o harm)
Comments: _____

Sexual Issues/Behaviors ☐ Yes ☐ No
Comments: _____

Please briefly describe why you are here today:

Bridges of OKFCC
Prenatal and Developmental History

Parent/Guardian, please fill out the following information to the best of your knowledge. This information will help us collect a complete and comprehensive history. We use this information to identify the best course of treatment for your child. If you do not know this information, please mark the following box: ☐ Prenatal History Unknown

Was the pregnancy planned? ☐ Yes ☐ No Mother's age at the time of birth: _____

Marital status of birth parents: ☐ Married ☐ Single/Not Married ☐ Separated ☐ Divorced ☐ Widowed
Was prenatal care received? ☐ Yes ☐ No Did the mother take any medications during pregnancy? ☐ Yes ☐ No
If yes, identify the medication(s) and reason for use: _____
_____

Did the mother drink, use drugs, or smoke during pregnancy? ☐ Yes ☐ No
If yes, identify the substance(s) and amount of use: _____
_____

Was the mother sick or have any complications during pregnancy? ☐ Yes ☐ No
If yes, please describe: _____
_____

How long was labor? _____ Birth weight: _____ Was the child delivered by c-section? ☐ Yes ☐ No
Did the child have any difficulties at birth (birth defects, injuries, or breathing problems)? ☐ Yes ☐ No
If yes, please describe: _____
_____

Does the mother have a history of postpartum depression (diagnosed)? ☐ Yes ☐ No If yes, indicate duration: _____

Developmental History If you do not know this information, please mark the following box: ☐ Dev. history unknown

From ages 0 to 2, did the child experience any issues with (please indicate all that apply):
☐ Touch ☐ Food ☐ Clothing Tags ☐ Loud Noises ☐ Textures

If you marked any of the early sensory issues above, please briefly describe: _____
_____

Please indicate the approximate age at which the child reached these milestones:
Crawled: _____ Walked Unattended: _____ Said Single Words: _____

Used Short Sentences: _____ Toilet Trained: _____

Please use the following space for any concerns/comments about milestones: _____
_____

Indicate any of the following behaviors observed during the first 5 years of life (recurring/happened most of the time or out of the ordinary):
☐ Did not like to cuddle ☐ Struggled with transitions/changes ☐ Unpredictable patterns of sleep or appetite
☐ Not calmed by being held ☐ Head banging ☐ Irritability ☐ Overly Active ☐Restless ☐ Difficult to feed
☐ Lethargic (always tired/sleepy or no energy) ☐ Cried Easily ☐ Never Cried ☐ Poor responses to new things

Please use the following space for any concerns/comments about any of these behaviors above: _____

Bridges of OKFCC
Medical Information/Emergency Contact Sheet

Allergies(Non-Medicinal): _____
Medication Allergies: _____
Current Medications/Dosages: _____
_____
_____
_____
Previous Medications/Dosages:_____
_____
_____
_____
Primary Care Physician: _____ Phone Number: _____
Primary Care Address: _____ Fax Number: _____
Emergency Contact: _____ Phone Number: _____
Relationship to Client: _____
Hospital to be transported to if needed: _____
Physical Conditions/Health Problems/Major Illnesses/Surgeries/Hospitalizations (Including Psychiatric), please include dates if applicable: _____
_____
_____
_____

Family Mental Health History Including Suicide(s), Trauma, and Chemical Dependency

Maternal Mental Health History

Relationship to Client	Age of diagnosis	Diagnosis

Paternal Mental Health History

Relationship to Client	Age of Diagnosis	Diagnosis

Sibling Mental Health History

Relationship to Client	Age of diagnosis	Diagnosis

Additional Comments/Information regarding any health history

Additional Comments:

Bridges of OKFCC
OTC Medication Consent

Name of Medication	Generic Name	Desired Effect	Common Side Effects	Food/Drug Interactions
Advil, Motrin Tylenol	Ibuprofen Acetaminophen	Reduces inflammation and eases mild to moderate pain Reduces fever Relieves mild to moderate pain and reduces fever. Has no anti-inflammatory effectiveness	Gas or heartburn, nausea and vomiting Serious side effects uncommon	Alcohol, aspirin, aspirin like medications, medications that may decrease blood clotting time
Maalox, Mylanta, Tums	Aluminum Hydroxide	Antacid that neutralizes or reduces stomach acid	Chalky taste, diarrhea, constipation	Aspirin like pain relievers *valproic acid absorption is increased by antacids
Benadryl Cream	Diphenhydramine topical	Over-the-counter product used for temporary relief of pain and itching associated with insect bites, minor skin irritations, and rashes due to poison ivy, poison oak, or poison sumac	Skin rash, hives and skin sensitivity to sunlight	Do not use with any other product containing diphenhydramine Diphenhydramine Topical has no listed severe interactions with other drugs.
Imodium	Loperamide	Used to treat sudden diarrhea (including traveler's diarrhea). It works by slowing down the movement of the gut. This decreases the number of bowel movements and makes the stool less watery	Dizziness, drowsiness, dry mouth, vomiting, constipation, fatigue and stomach pain or discomfort	Tell your doctor about all prescription, non-prescription, illicit, recreational, herbal, nutritional, or dietary drugs you are taking, especially saquinavir (Invirase) or pramlintide (Symlin)
Hydrocortisone Cream	Hydrocortisone	Reduces swelling, itching, and redness caused by a variety of skin conditions	Skin irritation or redness	Aspirin, acetaminophen, Benadryl, and certain anti-constipation medications
Neosporin/ Triple Antibiotic Ointment	Neomycin, Polymyxin B, and Bacitracin	Used to prevent infections	Skin irritation or redness	Acetaminophen, ibuprofen, certain anti-constipation medications, RID, melatonin
Sterile Eye Wash	Sod Borate-Boric Ac-Nacl-Water	Washes the eye to help relieve: irritation, discomfort, burning, stinging, itching, loose foreign material, chlorinated water and air pollutants	Stinging or redness in the eye, widened pupils, or blurred vision may occur	Not known to interact negatively with any medications or foods

I consent to basic medical treatment and to the above OTC medications. Please contact the office if you have any questions.

Parent/Guardian Signature: _____ Date: _____

Bridges of OKFCC
Prescription Medication Consent Form

ONLY FILL OUT IF THE NURSE WILL BE ADMINISTERING MEDICATION AT PROGRAM

Name of Medication:	Dosage:
Route:	Time/Frequency:
Reason:	Prescribing Doctor:

Name of Medication:	Dosage:
Route:	Time/Frequency:
Reason:	Prescribing Doctor:

Name of Medication:	Dosage:
Route:	Time/Frequency:
Reason:	Prescribing Doctor:

Name of Medication:	Dosage:
Route:	Time/Frequency:
Reason:	Prescribing Doctor:

I give permission for the administration of the above listed medication(s), according to the instructions listed, to the child listed above. I understand that a parent or legal guardian must deliver the medication directly to the nurse in its original prescription bottle. The label on the outside of the bottle must indicate the name of the medication, dosage, frequency, and that the medication belongs to the client. The prescription must also be current. The nurse will only administer medication according to the above guidelines.

Parent/Guardian Signature: _____
Date of Authorization: _____

RN USE ONLY:

RN Review Prior to Administering Medication	Yes	No
Is the Medication Consent Form complete?		
Is the original prescription label on the medication container?		
Is the first and last name of the child on the container?		
Is the prescription medication current?		
Is the name of the medication, dose, and frequency on the label consistent with the information written above?		

RN Initials: _____

Bridges of OKFCC
Psychiatric Evaluations/Parent Program Responsibility

I understand that:

- I will be given an opportunity to attend the psychiatric evaluation with my child.
- If I choose not to attend the evaluation, I will be contacted to discuss the doctor's recommendations.
- At no time will any medication be administered without my verbal/written consent.
- It is the decision of the parents/guardians to proceed with the recommendations made by the doctor.
- Every client in the program will be seen by a doctor *regardless of whether they are on medication or not.*
- I will provide a copy of my child's immunization records for their medical chart.
- It is a state requirement that there is a **current physical examination** performed by a physician in every client's chart. You are required to bring us one within 2 weeks of admission. Please initial here to acknowledge: _____
-

Please provide an email address to contact you regarding these appointments:

Email Address: _____

Phone Number: _____

I, _____, parent/guardian of the above-mentioned client, give permission for my child to be seen by Dr. Al-Botros for psychiatric evaluations as a requirement of participation in the partial hospitalization program.

Parent Program Responsibility

In order to provide the best treatment for our clients and to follow state guidelines, we require participation in family therapy on a weekly basis. It will be required upon starting the program that you attend a treatment plan session in which you will review and sign your child's treatment plan. You will also be required to attend weekly family therapy sessions that you will schedule with your child's therapist. If you are unable to attend, you must contact the therapist and reschedule your session. If you are unwilling to participate in family therapy sessions, your child's enrollment in the program may be revoked at the discretion of the treatment team.

I, _____, understand that participation in my child's treatment
(Print Name)
requires that I attend meetings, sign paperwork in a timely manner, and attend regular family therapy sessions. I also understand that I might see other families and children when I enter Bridges/OKFCC, and I will keep their information confidential.

Please indicate who will be coming to family sessions and their relationship to the client: _____
_____
_____

_____
Parent/Guardian Signature Date

Bridges of OKFCC
P.O. Box 1280
Bethany, OK 73008
P: (405) 577-5477 F: (405) 577-5488

AUTHORIZATION TO USE OR DISCLOSE PERSONAL HEALTH INFORMATION

☐ **El Reno** ☐ **Mid-Del** ☐ **Mustang** ☐ **Yukon**

Client Name: _____ DOB:_____ SSN:_____

Date(s) of Treatment: _____

I hereby freely and voluntarily authorize Oklahoma Family to: ☒ Release to ☒ Exchange with ☒ Obtain from

___**Program School District** (Indicate District:_____)_____
(Individual, Agency, or Organization) (Phone Number)

_____
(Address) (City, State, Zip) (Fax Number)

The purpose of this disclosure is for:

X Continued treatment X Educational X Legal reasons X Medical treatment
X Discharge planning X Client/guardian ___ Other (explain): _____

Information to be used/disclosed:

____X Intake and psychosocial history
____X Treatment summary including diagnosis
____X Immunization Records
____X Discharge summary/Aftercare Plan
____X School records
X Psychiatric Evaluation/Physician's Orders
X Psychological testing/evaluation materials
X Treatment Plan
X History and Physical
Other: _____

Restrictions: ___None_____

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease, or be related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment.

I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Oklahoma Family Counseling Centers' Privacy Officer, except to the extent that action has already been taken in reliance on it.

Reproduction of this authorization is as authentic as the original signed authorization. **This authorization will expire within 180 days following discharge unless another date or condition is specified.** Other date or condition specified _____N/A_____

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

Client signature: _____☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date of Authorization: _____

To recipient of release: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of

the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally prosecute any alcohol or drug abuse client.

Bridges of OKFCC
P.O. Box 1280
Bethany, OK 73008
P: (405) 577-5477 F: (405) 577-5488

AUTHORIZATION TO USE OR DISCLOSE PERSONAL HEALTH INFORMATION

☐ **El Reno** ☐ **Mid-Del** ☐ **Mustang** ☐ **Yukon**

Client Name: _____ DOB:_____ SSN:_____
Date(s) of Treatment: _____

I hereby freely and voluntarily authorize Oklahoma Family to: ☒ Release to ☒ Exchange with ☒ Obtain from

_(Indicate Pharmacy Name)_____
(Individual, Agency, or Organization) (Phone Number)

_____
(Address) (City, State, Zip) (Fax Number)

The purpose of this disclosure is for:
X Continued treatment __ Educational __ Legal reasons X Medical treatment
X Discharge planning __ Client/guardian __Other (explain): _____

Information to be used/disclosed (please check):
_____ Intake and psychosocial history
_____ Treatment summary including diagnosis
_____ Immunization Records
_____ Discharge summary/Aftercare Plan
_____ School records
X Psychiatric Evaluation/Physician's Orders
_ Psychological testing/evaluation materials
X Treatment Plan
X History and Physical
X Other: Information relevant to medication management

Restrictions: _____

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease, or be related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment.

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I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

Client signature: _____☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date of Authorization: _____

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AUTHORIZATION TO USE OR DISCLOSE PERSONAL HEALTH INFORMATION

☐ **El Reno** ☐ **Mid-Del** ☐ **Mustang** ☐ **Yukon**

Client Name: _____ DOB:_____ SSN:_____

Date(s) of Treatment: _____

I hereby freely and voluntarily authorize Oklahoma Family to: ☒ Release to ☒ Exchange with ☒ Obtain from

_____

(Individual, Agency, or Organization) (Phone Number)

_____

(Address) (City, State, Zip) (Fax Number)

The purpose of this disclosure is for:

__ Continued treatment __ Educational __ Legal reasons __ Medical treatment
__ Discharge planning __ Client/guardian __Other (explain): _____

Information to be used/disclosed (please check):

_____ Intake and psychosocial history
_____ Treatment summary including diagnosis
_____ Immunization Records
_____ Discharge summary/Aftercare Plan
_____ School records
_ Psychiatric Evaluation/Physician's Orders
_ Psychological testing/evaluation materials
_ Treatment Plan
_ History and Physical
_ Other: _____

Restrictions: _____

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease, or be related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment.

I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Oklahoma Family Counseling Centers' Privacy Officer, except to the extent that action has already been taken in reliance on it. Reproduction of this authorization is as authentic as the original signed authorization. **This authorization will expire within 180 days following discharge unless another date or condition is specified.** Other date or condition specified _____N/A_____

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

Client signature: _____☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date of Authorization: _____

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AUTHORIZATION TO USE OR DISCLOSE PERSONAL HEALTH INFORMATION

☐ **El Reno** ☐ **Mid-Del** ☐ **Mustang** ☐ **Yukon**

Client Name: _____ DOB:_____ SSN:_____

Date(s) of Treatment: _____

I hereby freely and voluntarily authorize Oklahoma Family to: ☒ Release to ☒ Exchange with ☒ Obtain from

_____

(Individual, Agency, or Organization) (Phone Number)

_____

(Address) (City, State, Zip) (Fax Number)

The purpose of this disclosure is for:

__ Continued treatment __ Educational __ Legal reasons __ Medical treatment
__ Discharge planning __ Client/guardian __Other (explain): _____

Information to be used/disclosed (please check):

_____ Intake and psychosocial history
_____ Treatment summary including diagnosis
_____ Immunization Records
_____ Discharge summary/Aftercare Plan
_____ School records
_ Psychiatric Evaluation/Physician's Orders
_ Psychological testing/evaluation materials
_ Treatment Plan
_ History and Physical
_ Other: _____

Restrictions: _____

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease, or be related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment.

I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Oklahoma Family Counseling Centers' Privacy Officer, except to the extent that action has already been taken in reliance on it. Reproduction of this authorization is as authentic as the original signed authorization. **This authorization will expire within 180 days following discharge unless another date or condition is specified.** Other date or condition specified _____N/A_____

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

Client signature: _____☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date of Authorization: _____

To recipient of release: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally prosecute any alcohol or drug abuse client

Bridges of OKFCC
BEHAVIOR MANAGEMENT POLICY

It is the policy of OKFCC to address crisis or emergency situations that involve disruptive or aggressive act(s) experienced by individual, family member and/or significant other.

The staff will intervene on all assaultive, aggressive, disruptive or self-destructive behavior (including property damage).

The staff will call other staff, security, or authorities to maintain the safety of the clients and others.

The client will be given the consistent message by the staff (verbally and in nursing actions), that the behavior is an unacceptable way to deal with feelings.

The staff will offer alternative methods of handling feelings.

The threatening of staff or clients will be dealt with calmly while informing the client that the behavior will not be accepted or tolerated.

Should a client physically attack someone, the agency will physically restrain the client using an approved behavior management technique such as Handle With Care.

Bridges of OKFCC employs a time-out procedure. Clients placed in time-out will be with a staff member at all times.

Oklahoma Family Counseling Centers

Notification of Restraint/Seclusion Policy

It is the policy of Oklahoma Family Counseling Centers, based on the philosophy of the agency, not to use any mechanical restraints or closed-door seclusion. Therapeutic holds may be employed when the client fails to respond to verbal cues to act safely. Mechanical restraints of clients will not be used as a therapeutic or intervention technique. All staff will be trained in anger de-escalation as an intervention technique. Parents/guardians will be notified of restraint procedures through communication with the assigned therapist and/or the staff nurse.

I, _____ give consent for OKFCC to perform behavioral management, including physical restraint, when deemed necessary and ordered by the Program/Clinical Director, a Clinical Director, and/or the OKFCC Medical Director.

Parent/Guardian Signature: _____ Date: _____

Bridges of OKFCC
CLIENT ORIENTATION CHECKLIST

I affirm that I have been provided an orientation to the program, its staff, services and facilities, including each of the following areas listed below:

___ 1. Hours of operation
___ 2. Code of Ethics
___ 3. Rules, Regulations, and Expectations
___ 4. Client rights and responsibilities of person served
___ 5. Client Fee System explanation, financial arrangements, fees, obligations
___ 6. Complaint, grievance and appeal procedures
___ 7. Full disclosure on all levels, types and duration of services and activities
___ 8. Access to after-hours services
___ 9. Identification of counselor / service coordinator
___ 10. Ways in which client input is given re: quality of care, outcomes, and satisfaction
___ 11. Copy of program rules to client specifying and restrictions the program may place on a person, events, behaviors or attitudes and their likely consequences, that may lead to a loss of privileges and the means by which the lost rights / privileges can be regained by the client.
___ 12. Developing feasible goals and achievement of outcomes
___ 13. Confidentiality policies
___ 14. Site and Safety organization (Familiarization with premises, emergency exits and/or shelters, fire suppression equipment, first aid kits, etc.)
___ 15. Use of Tobacco policy
___ 16. Purpose and process of assessment
___ 17. Description of how the Individual Plan is developed and client participation in it
___ 18. The potential course of treatment services
___ 19. Aftercare / Transition and Discharge Criteria and procedures
___ 21. Policy on seclusion and restraint
___ 22. HIV, Hepatitis B and C, other infectious diseases and universal precautions
___ 24. Policy regarding illegal / legal drugs or prescription medications brought into the program
___ 25. Policy regarding weapons brought into the program
___ 26. Expectations regarding legally required appointments, sanctions, or court notifications
___ 27. When applicable, the identification of therapeutic interventions including sanctions,motivational incentives and administrative discharge criteria
___ 28. Intent / Consent to Treat
___ 29. Behavioral expectations of the consumer
___ 30. Standards of professional conduct related to services

I have been oriented by the staff at OKFCC and understand the above-initialed items.

Client signature: _____ ☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date: _____

Bridges of OKFCC
Intake Appointment Satisfaction Survey

Please complete at the end of your intake appointment

Which location did you attend for your intake assessment?

☐ **El Reno** ☐ **Mid-Del** ☐ **Mustang** ☐ **Yukon**

What services are you interested in starting?
□ PHP □ Outpatient Counseling

Who referred you to our agency? _____

Calling to Arrange an Assessment-Thinking back to your initial call to OKFCC, please rate your agreement with the following statements:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	NA
The person I spoke to was friendly and helpful	□	□	□	□	□	□
My first appointment was scheduled in a timely manner	□	□	□	□	□	□

Intake Appointment-Thinking about your intake appointment, please rate your agreement with the following statements:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	NA
The office staff was friendly/helpful when I checked in…….	□	□	□	□	□	□
The clinician I saw was prepared for my visit……	□	□	□	□	□	□
I felt the clinician paid attention to what I had to say…….	□	□	□	□	□	□
The clinician seemed to understand my concerns……	□	□	□	□	□	□
The clinician seemed thorough and competent……..□		□	□	□	□	□
I received as much information as I needed ……..□		□	□	□	□	□

Overall, how satisfied do you feel with OKFCC at this time? (circle one)

Very Satisfied
Satisfied
Neither Satisfied nor Dissatisfied
Dissatisfied
Very Dissatisfied

How likely would you be to recommend OKFCC to a friend or family member at this time? (circle one)

Would definitely not recommend Would definitely recommend

1 2 3 4 5 6 7 8 9 10

Bridges of OKFCC
CLIENT RIGHTS

OKFCC & Dr. Al-Botros will be responsible for ensuring the implementation and maintenance of the client rights activities for all clients participating in organization services and other activities. Client Rights will be communicated to clients in a manner that is meaningful.

CLIENT RIGHTS

You have the right to a comprehensive copy of your "Client's Rights" as set forth in accordance with the Oklahoma Department of Mental Health and Substance Abuse Services. For your comprehensive copy please ask the Administrative Assistant or call (405) 577-5477 to request your copy. Thank You.

COMMUNICATION OF CLIENT RIGHTS

Clients' Rights are posted in all OKFCC administrative offices and clinics. As a routine part of the initial interview process, each client(s) will receive a copy of his/her/their rights and have them explained to him/her/them in language that is understandable. If the client's primary language is other than English, a copy of the clients' rights will be provided in the native language (to the extent possible). Documentation that these rights have been received and explained is to be indicated by the client signature on the client orientation checklist

CLIENT RIGHTS

ALL PERSONS RECEIVING SERVICES FROM OKFCC SHALL RETAIN AND ENJOY ALL CONSTITUTIONAL, STATUTORY RIGHTS, BENEFITS AND PRIVILEGES GUARANTEED TO ALL CITIZENS OF THE STATE OF OKLAHOMA AND THE UNITED STATES OF AMERICA, EXCEPT THOSE SPECIFICALLY LOST THROUGH DUE PROCESS BY A COURT OF LAW. IN ADDITION, ALL PERSONS SHALL HAVE THE RIGHT GUARANTEED BY THE SUBSTANCE ABUSE CLIENT'S BILL OF RIGHTS, UNLESS AN EXCEPTION IS SPECIFICALLY AUTHORIZED BY THESE STANDARDS OR AN ORDER OF A COURT OF COMPETENT JURISDICTION. EACH CLIENT SHALL BE NOTIFIED OF THESE GUARANTEED RIGHTS AT ADMISSION. SHOULD THE CLIENT BE A MINOR, HIS/HER PARENT OR LEGAL GUARDIAN, INCLUDING COURT ORDERED GUARDIANS, SHALL ALSO BE INFORMED. IF THE CLIENT CANNOT UNDERSTAND THE LANGUAGE IN THE BILL OF RIGHTS, AN ORAL EXPLANATION SHALL BE GIVEN IN A LANGUAGE THAT THE PERSON CAN UNDERSTAND. EACH PERSON SERVED BY OKFCC CAN EXPECT:

1. To be treated with respect and dignity. All OKFCC personnel are expected to perform all services in a manner that protects, promotes, and respects individual human dignity.

2. The right to a safe, sanitary and humane treatment environment.

3. The right to a humane psychological environment that protects him/her from harm, abuse, neglect, and/or exploitation.

4. To be provided services in an environment which provides reasonable privacy, promotes personal dignity, and provides the opportunity for improved functioning.

5. To be afforded the opportunity to participate in the treatment planning, and receive information regarding the treatment to be provided in order for informed consent, or refusal of consent, to be given to the proposed treatment. This shall stand unless a court of competent jurisdiction or, in emergency situations as defined by law, abridges the rights of the client.

6. The right to receive service(s) and/or appropriate referral suited to his/her conditions and needs without regard for race, color, age, gender, marital status, sexual orientation, religion, spiritual values, ethnic origin, co- occurring disorder, degree of disability, handicapping condition, legal status, and/or the ability to pay for the services.

7. To never be neglected and/or sexually, physically, verbally or otherwise abused, harassed, humiliated or punished.

8. The right to be provided with prompt, competent, appropriate services and an individual treatment plan.

9. The right to permit family members or significant others to be involved in their treatment and treatment planning.

10. The right to not be subjected to unnecessary, inappropriate, or unsafe termination from treatment. Discharge shall not take place as punishment for displaying symptoms of the client's disorder.

11. The right to have their records treated in a confidential manner within 42 CFR part 2 and HIPAA regulations.

12. The right to review their records according to the policies and procedures set forth by OKFCC that are in accordance with State and Federal laws including 42 CFR part 2 and HIPAA regulations.

13. The right to refuse to participate in any research project or medical experiment without specific informed consent as defined by law and that such refusal shall not affect the services available to the person served.

14. The right to request the opinion of an outside medical or psychiatric consultant, at the expense of the person served; and/or to request an internal facility consultation at no cost.

15. The right to assert grievances with respect to any alleged infringement of these stated rights or any other statutorily granted rights.

16. The right to never be retaliated against, or subject to any adverse conditions or treatment services solely or partially because of having asserted any of the person served rights listed in this document.

17. The right to mechanisms that will facilitate access and/or referrals to legal services, advocacy services, self-help groups, guardians and conservators.

18. The right to be informed that services can be refused and that there could be consequences to refusal of services.

19. The right to an expression of choice of release of information.

20. The right of choice of concurrent services.

21. The right of choice of composition of treatment team.

OKFCC's policy is to train all staff, contract employees, students, and volunteers in these rights and to insist on their observance as part of staff's program specific orientation. OKFCC policy and procedure is to ensure each client enjoys these rights and has explained to him/her these rights. These rights are visibly posted in public areas of the facility.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Bridges of OKFCC
CONSENT FOR TREATMENT

Client Name: _____ DOB: _____

Benefits of Treatment:
Treatment can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems such as; anxiety, anger, depression, parenting or relationship concerns. Treatment can help a person develop new skills and to change behavior patterns. Treatment can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others.

Risks of Treatment:
I acknowledge that OKFCC has advised me and my child that while there are potential benefits to treatment, there is no guarantee of success and that there are potential risks. I have been advised that during treatment emotions and memories may be stimulated which can evoke strong feelings and that changes in awareness may alter self-perceptions and ways of relating to others. I have been advised that personal change can be quite varied and individual.
I understand that it is important to mention any concerns or questions that I have at any time during the process of treatment.

Services:
I understand that services provided, and that may be deemed necessary or appropriate by OKFCC Clinical Staff, include:

- Psychiatric Evaluations
- Individual Therapy
- Group Therapy
- Family Therapy
- Group Rehabilitation Services
- Individual Rehabilitation Services
- Other treatment as deemed necessary or appropriate

Consent:
In knowledge and appreciation of the benefits and risks as made known to me by OKFCC, and as reflected in this form, I hereby give my consent for my child to participate in treatment.

Confidentiality and Limits of Confidentiality:
I have been advised that all communications and records relating to treatment services are confidential and may not be disclosed without my written consent. I have also been advised that the law places certain limits on the confidential nature of the treatment services provided to me. I have been advised that these limits on confidentiality may arise if it is perceived that there is risk of harm in situations such as the following:

- if my child or I present an imminent danger to myself or others the law requires that steps be taken to prevent such harm;
- if a child is in need of protection a report must be filed with the appropriate agency or authority;
- if a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency;
- or if a court orders the disclosure of records

Acknowledgment and Consent:

I _____ acknowledge that I have had the opportunity to carefully read this document to ask, and have answered any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document, that it records my consent for treatment of myself and/or my child, and I have been given the opportunity to request a copy of it this _____ day of _____, 20___.

Client signature: _____ ☐N/A, Client Under Age 14 Date: _____

Parent/Guardian: _____ Date: _____