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ADMISSIONS AGREEMENT

Initial each paragraph agreed to:

I _____ (client or parent/legal guardian if under 18) give my consent and agree to the following:

_____Request admission for myself, child or ward to NIALife Center for Counseling, LLC for periodic services and treatment, understand that I will not be deprived of my legal rights and responsibilities and that I can discharge myself, child or ward from NIALife Center for Counseling, LLC upon written and/or verbal notice to the Administrator. I have received a copy of my Bill of Rights developed by Magellan Behavioral Health and as written in policy and has been explained to me. In addition, I acknowledge that I have received information concerning Client's Rights and the Grievance Procedures.

_____ I acknowledge that the confidentiality regulations have been explained to me. I understand that no employee, contractor or visitor to NIALife Center for Counseling, LLC can divulge information to any unauthorized person without my knowledge and written consent. I also understand that divulging confidential information to unauthorized persons is a misdemeanor and is subject to civil penalties. I understand it is the policy of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services that as a client in one of its agencies, I (child or ward) shall receive appropriate treatment and continuity of care. In order to accomplish this, information may be shared between treating agencies for quality care without consent in accordance with a. s. 122C-52 through 122C-56, to comply with G.S. 122C-54 (h), this agency is required to disclose confidential information for the purpose of complying with mandatory reporting and disclosure law relevant to the suspicious of abuse, neglect or dependency of children.

_____ I understand that NIALife Center for Counseling, LLC , its personnel, contractors and client's attending physicians will NOT be held responsible for any accidents or the deterioration of the client's condition while out in the community and in any of the above person's care.

_____ I have received my Handbook and have been orientated to NIALife Center for Counseling ,LLC. I agree to follow the policies and procedures of the organization. I understand my rights and responsibilities as a recipient of services and that failure to fully participate as described by the regulations of NIALife Center for Counseling, LLC may result from discharge from the agency.

____ I was educated and provided information by NIALife Center for Counseling, LLC Providers regarding my or my child's diagnosis and treatment.

RESTRICTIVE INTERVENTION AND/OR PHYSICAL RESTRAINTS

_____I understand that NIALife Center for Counseling, LLC does not use physically restrictive methods such as seclusion and restraints. In the instance, a client becomes aggressive and is in danger of harming themselves or others, 911 emergency services will be notified.

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CENTER FOR COUNSELING

_____ I have received a full explanation of the use of physical restraints. I understand that physical restraints is defined here as a therapeutic hold carried out by a staff member used exclusively for the purpose of preventing a client from doing damage to self or others and never as a form of punishment. I understand that at no time will excessive force or mechanical constraints be used to restrain a client. I understand that I will be notified of any incidents requiring the use of physical techniques with this client.

_____ I authorize NIALife Center for Counseling, LLC to provide first aide assistance to the client while in the care of its team members.

_____ I will be notified of any serious illness, any changes in medical treatment.

_____ I do not want visits or contact with the following people:

_____
_____
_____
_____

SIGNATURES:

_____
Patient Name Date

_____
Parent/Guardian (if applicable) Date

Refusal to Sign Date

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Office Use Only:
Patient Number: _____

CONSENT FOR USE, DISCLOSURE AND/OR RELEASE OF PERSONAL AND HEALTH INFORMATION

Patient Last Name	First Name	Middle Initial
Date of Birth	Telephone Number	
Address	City, State,	Zip Code
Parent/Guardian/Caretaker Name (If applicable)	Relationship to Patient	

I. PERSON OR AGENCY ***REQUESTING*** THE INFORMATON

The persons or agency can request the patient's personal, health and/or education information. (The information to be released is described in section III. below.)

Agency Name:		
Address:	City/State	Zip Code
Agency Contact and Title		
Telephone Number	Fax Number	

II. PERSON OR AGENCY ***PROVIDING*** THE INFORMATON

The persons or agency may release the patient's personal, health and/or education information; (The information to be released is described in Section III below.)

Agency Name:		
Address:	City/State	Zip Code
Agency Contact and Title		
Telephone Number	Fax Number	

III. INFORMATION THAT MAY BE RELEASED:

The person or agencies marked in Section I above may view, copy, release and exchange the information or records marked below. (Please check all that apply to the patient's needs now and in the future.) This information may be shared verbally, in writing and/or by email or fax:

- ☐ Medical Information, including but not limited to operative, emergency, radiology, consultations, progress notes
- ☐ Developmental Information
- ☐ Speech/Language
- ☐ Educational Records
- ☐ Developmental Screening Information
- ☐ Mental Health/Psychological Records
- ☐ Other:_____

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SPECIFIC AUTHORIZATIONS: The following information will not be released unless you specifically authorize it by marking the relevant box below:

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code (SS5328, et seq)

THE PATIENT'S INFORMATION MAY BE USED TO:

1. Get more services
2. Allow various professionals to understand the patient's development.
3. Allow various professionals to help coordinate medical and non-medical services for the patient.

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form and it will not affect the services I and/or my child gets from this agency.

LENGTH OF TIME: This consent will be valid from the date I sign this form until _____ (date). If no date is entered, the form will be valid for one year after the date that I sign the form.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I sign the consent form.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency in Sections I and II. The information may no longer be protected by the HEALTH Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other state and federal laws.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent from if I ask for one.

Print Full Name	Signature
Relationship to Patient (If applicable)	Date

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PATIENT EMERGENCY CONTACT FORM	
Patient Name:(Last) (First) (M.I)	Date of Birth:
Parent/Guardian Name (If applicable):	Telephone Number:
Patient Address:	
Emergency Contact Name:	Telephone Number:
Relationship to Patient:	Alternate Telephone Number:
Emergency Contact Address:	

I_____, give permission to NIALife Center for Counseling, LLC staff to contact the above listed person at the telephone number and address above in case of a medical or mental health emergency. I understand that personal information about the patient's medical treatment and care may be shared with the above named emergency contact person.

The permission to contact the emergency contact person listed above may be revoked at any time and immediately upon discharge. Consent to contact the above person lasts up to one year from the date of this signed release.

Patient (If older than 21) Date

Parent/Guardian Date

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Child & Adolescent Behavioral Health Rehabilitation Program
Parent/Guardian Treatment Participation Agreement

Patient Name:	(Office Use)Patient Number:
Parent/Guardian Name (Print)	

The Child & Adolescent Behavioral Health Rehabilitation Program requires you as the parent/guardian to be involved and active in the treatment process of your child. In order to receive services in the Child & Adolescent program, we are required by the Louisiana Department of Health and Hospitals to have the full participation of the patient and parent/guardian. Our Child & Adolescent Behavioral Health Program works from a family systems model. We incorporate the entire family in the treatment process. You, as the parent/guardian, are an important part of the process. Therefore, we ask you to read this agreement carefully.

As a parent/guardian of a child being provided services by the Child & Adolescent Behavioral Health Rehabilitation team, I agree to participate in treatment in the following ways and understand that failure to do so may result in the discharge of my child from services due to noncompliance.

1. I agree to receive services from the Child & Adolescent Behavioral Health Rehabilitation team to include:
    - Licensed Behavioral Health Professional
    - Behavioral Health Professional
    - Behavioral Health Specialist

2. I will make my child available for weekly sessions with a member of the treatment team for counseling, psychosocial skills training and community psychiatric support & treatment.

3. I understand failure to participate in sessions in a safe, sanitary and private environment may cause discharge due to noncompliance.
4. I, the parent/guardian, agree to communicate weekly with a member of the treatment team in regards to my child's treatment progress.
5. I agree to participate in treatment team meetings with my child and the treatment team once every 6 months and as needed to review treatment progress and update information.
6. I will maintain a current copy of my child's treatment plan and crisis plan and understand I may ask for a copy at any time.
7. I understand that my child has been diagnosed with a mental health disorder.
8. I will notify the Child & Adolescent Behavioral Health Rehabilitation Program of any changes to my contact information to include address, telephone numbers or email address.
9. I understand my rights of confidentiality as well as limits to confidentiality regarding my child's services.
10. I understand my rights as a person served by the Child & Adolescent Behavioral Health Rehabilitation Program.
11. I will treat the staff of the Child & Adolescent Behavioral Health Rehabilitation Program with respect and abide by the policies, procedures, regulations, and rules of the organization.
12. I understand I may discontinue services for my child at any time with verbal or written notification.

Parent/Guardian Signature Date

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PHYSICIAN INFORMATION FORM

Patient Name:	(Office Use Only)Patient Number:	
Address:	Telephone Number:	
Parent/Guardian (If applicable):		
Primary Care Physician (PCP):	Telephone Number:	Fax Number:
PCP Address:		
Psychiatrist:	Telephone Number:	Fax Number:
Psychiatrist Address:		
Other Physician:	Telephone Number:	Fax Number:
Physician Address:		
Please List All Medications:		
Please List All Current Medical and Psychological Diagnoses:		
Please List All Allergies:		
Identify any important medical information:		
Signature:	Date:	

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PATIENT INFORMATION

Patient Name (Last) (First) M.I			Home Phone
Address			Cellular Number
City/State	Zip Code	D.O.B	Soc. Sec. #
Race ☐ African American/Black ☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Caucasian ☐ Native American ☐ Other:_____	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er)	Age:
Employer/ School:			(If applicable) Grade:

RESPONSIBLE PARTY

Name of Parent/Guardian	Phone Number if Different from Above	
Address (If different from above)	Employer:	Work Number: none
Relationship to the Patient ☐ Mother ☐ Legal Guardian ☐ Foster Parent ☐ Father ☐ Family Member ☐ Other:_____	Occupation:	Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er)

INSURANCE INFORMATION

Medicaid ☐ Yes ☐ No	Medicaid Number:	
Primary Insurance Company Name:	Person Carrying Insurance:	
Is Insured Through Employer? ☐ Yes ☐ No	Employer:	
Insured Birthdate:	Patient's Relationship to the insured	
Policy Number:	Group Number:	Insured Social Security Number:
Secondary Insurance Company Name:	Person Carrying Insurance:	Is Insured Through Employer? ☐ Yes ☐ No
Employer:	Insured Birthdate	Patient's Relationship to the insured
Policy Number:	Group Number:	Insured Social Security Number

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize release of any Medical Information to process claims related to my treatment and authorize Payment of medical benefits to this service provider.

Signed **X** Date:

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Orientation to Behavioral Health Rehabilitation Program

Patient Name:	(Office Use) Patient Number:

Included in your orientation handbook are the following policies, forms and expectations:

- Identification Form
- Brochure
- Code of Ethics
- Patient Rights & Responsibilities
- Crisis procedures with telephone numbers
- Complaints, grievances and appeals procedures & forms
- Ways in which input can be given (Satisfaction Survey)
- Confidentiality Policy
- Abuse & Neglect Policy
- Seclusion & Restraint Policy
- Behavioral Health Rehabilitation Program Description
- Behavioral Expectations of the Person Served
- Discharge Criteria
- Transition Criteria and Procedures
- Response to the identification of potential risk to the person served
- Standards of professional conduct related to services
- Requirements for reporting and/or mandated person served
- Fee Schedule
- Health & Safety Policies
- Rules & Expectations
- Familiarization with the premises included emergency exits, fire suppression equipment and first aid kits
- Identification of the purpose & process of the assessment
- A description of the person centered plan
- Potential course of treatment
- Motivational Incentives
- Expectations for legally required appointments, sanctions or court notifications
- Identification of the person responsible for service coordination

I have received my orientation handbook; have been orientated and agree to follow the policies and procedures of the behavioral health rehabilitation program. I understand my rights and responsibilities as a recipient of services and that failure to fully participate as described by the behavioral health rehabilitation program may result in discharge from treatment.

Patient Signature (If over 18):	Date
Parent/Guardian Signature (If applicable):	Date
Person Responsible for Coordinating Services Signature:	Date

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Member's Freedom of Choice

The provider I choose is:

NIALife Center for Counseling,LLC
2929 Millerville Rd. Building 1 Suite E
Baton Rouge, LA 70816

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. I am choosing to discontinue services with any other previous provider and obtain services from the above provider.

Member Name:	**Member Date of Birth:**

Member/ Legal Guardian Signature:	**Legal Guardian Name:**

Today's Date:

Provider Signature: