HEALTHQUEST PATIENT REGISTRATION

❑ Check box if patient is a minor/adolescent

PLEASE FILL OUT ALL FORMS COMPLETELY, Use N/A if not applicable. Date: ___/____/___

Patient Name: _____ DOB_____/_____/_____
First Middle Last

Social Security Number: _____ Driver's' License Number: _____

Address_____

Home#: _____ Cell#: _____ other# _____

Sex: ❑Male ❑Female **Marital Status:** ❑ Single ❑ Married ❑ Divorce ❑Separated

Highest Level of Education: ❑9 ❑10 ❑11 ❑12❑Masters

Ethnicity/Race: _____Religion:_____

❑Student ❑Unemployed

Employer: _____ Phone#: _____

Address: _____ Title: _____

List people who we are allowed to contact on your behalf and share your medical information with:

Contact: _____
Name Phone# Relation to You

Contact: _____
Name Phone# Relation to You

Contact: _____
Name Phone# Relation to You

Insurance Information: ❑ Self Pay

Primary: _____ Secondary: _____
Policy/ID#: _____ Policy/ID#: _____
Group/Account#: _____Group/Account#: _____
Responsible Party for Insurance: ❑Self ❑Spouse❑ Parent/Guardian
Name: _____ DOB: _____/_____/_____
Social Security Number: _____ Phone#: _____
Employer: _____ Phone#: _____

IF THIS IS AN EMPLOYEE ASSISTANCE PLAN, you are required to contact the EAP office prior to Visiting our office. Did you contact the EAP office? ❑NO ❑YES If Yes:
Authorization#: _____ #of visits _____ Name of EAP: _____

HEALTHQUEST: Release of Medical Information Consent

Patient Name: _____ DOB _____/_____/_____

Consent to Release Confidential Information to Primary Care Physician and/or Other Healthcare Physicians

List all physicians and/or facilities with phone number giving HealthQuest permission to share records:

1_____

2_____

3_____

4_____

5_____

Confidentiality of alcohol and drug abuse records are protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

I understand the release of this information is to permit my treating physician and other healthcare physicians to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year, on the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

- ❑ I authorize the release of my medical information to the physicians listed above.
- ❑ ALL medical records
- ❑ Limited treatments and/or dates
- ❑ I DO NOT wish to have any of my medical information shared.

_____ _____/_____/_____

Signature of Patient or Guardian **(relationship to patient)** **Date**

_____ _____/_____/_____

Witness **Date**

HEALTHQUEST: MEDICATION CONSENT FORM

Patient Name: _____ **DOB** _____/_____/_____

I have been informed of the recommendation of the medication(s) listed below are being prescribed as a part of my treatment program. I have been informed of the nature of my condition, the risks and benefits of treatment with the medication(s) listed below, of other forms of treatment, and the risks of no treatment. Signing this form indicates that I have received information explaining the most common side effects of the medication(s) and have understood the explanation of the side effects.

I understand that medication is only one aspect of my overall treatment, and that success and improvement depends on my active involvement and participation in all aspects of the treatment plan developed for me. I also understand that although this medication is expected to be helpful in the treatment of my condition, there is no absolute guarantee as to the results. I am required to report to my provider the side effects I experience while taking the medication. Before given the medication, the psychiatrist will explain in detail the nature of your condition, why you are being prescribed the medication, the risks and benefits of treatment by taking the medication, and/or forms of other treatments if you do not want to take the medication.

FOR FEMALES: Because the medication(s) could be harmful to a developing fetus, you need to notify your provider of the medication(s) given immediately if you suspect pregnancy or have plans to become pregnant.

❑ I give permission/consent to the administration of the prescribed medication(s) knowing the risks, benefits, and side effects.

❑ I **REFUSE** to allow the administration of the recommended medication(s) and **REFUSE** what alternative medication(s) and treatment that are offered.

_____ _____/_____/_____

Signature of Patient or Guardian **(relationship to patient)** **Date**

_____ _____/_____/_____

Witness **Date**

HEALTHQUEST: Policy and Consent

Patient Name: _____ DOB _____/_____/_____

I agree that I have been given and read the HealthQuest Notice of Privacy Practices. I agree that I understand the meaning of the notice policies. I agree that I have had all my questions about fees, confidentiality, insurance, and medication(s) explained to my satisfaction.

_____ _____/_____/_____

Signature of Patient or Guardian **(relationship to patient)** **Date**

Medication Requests

It is important for you to keep your appointment to ensure proper medical treatment. However, HealthQuest understands at times there will be a need for you to reschedule your appointment. HealthQuest reserves the right to not call in medications for you when you miss, cancel, or reschedule your original appointment and not fill medications until you are seen again. It is important for your HealthQuest psychiatrist to evaluate your progress and side effects before refilling your medications. When rescheduling your appointment, you will be scheduled on the next available appointment. If medications are called in, there you will be responsible for a $20 administrative fee for processing the refill request which will not be billed to your insurance company.

_____ _____/_____/_____

Signature of Patient or Guardian **(relationship to patient)** **Date**

Miscellaneous Forms

Short and Long Term Disability, FMLA, Questionnaires, Assessments, Letters, Narratives, etc. HealthQuest is a private practice that charges a fee for services. Completion of forms and request for letters are sometimes not covered by your insurance. Therefore the responsibility of paying for the request becomes the patient's responsibility. When you ask for the request, a request form must be completed, and payment is due at time of the request. Completion of the request will take up to 10 business days. Once the request is completed, someone will contact you. By signing this portion, you agree to these terms for future references. _____
_____/_____/_____

Signature of Patient or Guardian **(relationship to patient)** **Date**

HEALTHQUEST: Insurance Authorization to Pay Benefits

Patient Name: _____ DOB _____/_____/_____

For All Patients who have Private Insurances:

I hereby authorize HealthQuest to file any medical claims on my behalf. I authorize payment to HealthQuest for services rendered to my dependents and myself. I also authorize HealthQuest to release any information necessary to expedite insurance reimbursement.

_____ _____/_____/_____

Signature of Patient or Guardian (relationship to patient) Date

For All Patients who have Medicare:

I hereby authorize payments to HealthQuest on my behalf from Medicare benefits for any services furnished to me. I authorize any holder of my medical information to be released to the Health Care Finance Administration and its agents for the information. This release shall be in effect for the entirety of my treatment at HealthQuest. I agree to pay for services rendered that are not covered by Medicare such as missed appointments, telephone consults, completion of disability forms, legal depositions, non-routine medication refill calls as outlined in the practice policy, and any other non-routine forms. I also agree that I will pay for any lab work required not covered by Medicare. I also agree to pay any coinsurances and deductibles owed. Medicare has an 80/20 payment plan, so patients who have just Medicare are responsible for the 20% part. The copayment for each visit for the 20% part will be $25.65, and patient will be responsible for paying $25 for the urine drug screens as well due to it not being covered by Medicare.

_____ _____/_____/_____

Signature of Patient or Guardian (relationship to patient) Date

For All Patients who have Workmen's Compensation as your Insurance Carrier:

I hereby authorize payments to HealthQuest on my behalf from Workmen's Compensation benefits for any services furnished to me. I authorize any holder of medical information about me to be released to the Workmen's Compensation carrier and its agents for any needed information to determine these benefits and for the benefits payable for related services. I authorize HealthQuest to send such information. I further authorize HealthQuest to send any treatment notes that may be requested by Workmen's Compensation and its agents. This release shall be in effect for the entirety of my treatment at HealthQuest. I agree to pay for services rendered that are not covered by Workmen's Compensation such as missed appointments, telephone consults, completion of disability forms, legal depositions, non-routine medication refills as outlined in the practice policy and any other forms that are non-routine.

Workman's Comp Claim Number _____

Workman's Comp Phone Number _____

_____ _____/_____/_____

Signature of Patient or Guardian (relationship to patient) Date

HEALTHQUEST: Policy and Consent

Patient Name: _____ **DOB** _____/_____/_____

Clear and direct communication is important for effective psychiatric and psychological services. Please speak with any HealthQuest employee, therapist, or physician about any questions you may have about your treatments or/and about any of our services provided to you.

CONFIDENTIALITY: Information regarding services provided is controlled by the patient. There are several exceptions to this rule.

1. Under the law HealthQuest is to take whatever action seems necessary to protect anyone from doing harm to themselves or/and harm to anyone else.
2. HealthQuest is required to contact the Department of Human Services if there is reason to believe a patient, child, or dependent adult is being abused, neglected or harmed in any way seen unfit.
3. If you have been referred to HealthQuest for court purposes, please discuss with the physician the reason for your visit and what the court is needing from HealthQuest. The court will receive the evaluation report.
4. If you are involved in legal actions of any kind and inform the court of the services you receive from us (making your mental health an issue for court), you may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received treatment at HealthQuest.
5. If you are referred by another professional, communication regarding pertinent treatment considerations will be maintained with that professional only if you have signed a consent form allowing us to discuss your treatment or/and send any medical records, unless you specify in writing to the contrary. Please discuss with us any questions you have regarding the confidentiality of information you share with us.
6. Most insurance companies, other payers, and/or managed care companies require the release of medical and mental information regarding diagnoses, evaluations, date of services, treatment plans, and/or any other confidential information.

BENEFIT AND RISK of THERAPY: Therapy is an interactive process to promote change and understanding between the patient, the therapist, and the psychiatrist. Therapy can be emotionally painful but can also be fulfilling at times. You will be expected to distribute to all decisions regarding the interventions and treatment plans advised for you, including out of session task, laboratory services, and urinary drug screens. You have the right to refuse or alter any intervention or service. You should question the rationale of treatment if it is unclear to you. While we have every expectation of helping you determine and achieve personal therapeutic goals, we cannot guarantee any specific outcome.

In the event you have a need for services after hours, on holidays, or when the office is closed, HealthQuest has a 24-hour answering service for your convenience, which will notify our staff immediately. A HealthQuest provider will call you back. For emergencies please call “911”. The Suicide Crisis Hotline is also available to you.

_____ _____/_____/_____

Signature of Patient or Guardian **(relationship to patient)** **Date**

_____ _____/_____/_____

Witness **Date**

HEALTHQUEST: Financial Agreement

Patient Name: _____ DOB_____/_____/_____

HealthQuest is a private practice where all services require a fee which is the responsibility of the patient or guardian. Copayments are required to be paid at the time of each visit before being seen by the physician. Copayments are required to be paid at the time of each group and individual session for Intensive Outpatient Therapy and Focus Groups and Suboxone Therapy. The patient's responsibility is to find out what their copayment will be for seeing the physician and for Intensive Outpatient Therapy and Focus Groups and Substance Abuse Therapy.

Please understand that the filing of any insurance claim and sending of all statements are performed as a courtesy. All services that are not covered by the insurance company will be the responsibility of the insured party to follow up with the insurance company and to pay all remaining balances unless there is a contract between the insurance company and HealthQuest that states differently. You may check with the insurance department at HealthQuest for said contracts and carriers.

All balances remaining where the insurance carrier does not pay is the patient's or guardian's responsibility. Statements will be sent out with the balances that need to be paid. If the balances are not paid or balances increase to a point the patient or guardian are not able to pay in full, a HealthQuest associate will explain the circumstances of the balance and be able to set the patient or guardian on a monthly payment plan. Once the payment plan is set, it is up to the patient or guardian to either send in payment or call the billing department to pay over the phone each month.

Patient's unpaid account will become delinquent after it has matured to 121 days from the date of service of last office visit or from the date the payment plan agreement was signed. Once the account has become delinquent, it will be sent to collections, and there will be an added 33% to the account balance. Patient or guardian will be responsible for all collection fees or/and attorney fees for delinquent accounts.

Payments for Services:
$50 for "No Show" appointments; must call to cancel appointment 24 hours in advance
$20 for Non-Routine Medication Refill Requests.
$100 for Medical Forms and Letters and Legal Documents which a request must be filled out for.
Medical Record Fees: All records will be subject to a copying fee. The current fee schedule is $20.00 for the first five (5) pages, and $0.50 for every page after. **Wellness Clinic** records are stored at an off-site location, and have different fees. The fees for these records are $20.00 for the first twenty (20) pages, $1.00 for pages 21-80, and $0.50 for every page after.

Patient or guardian is fully responsible for the payment of these miscellaneous fees whether paid or denied by the insurance company unless stated otherwise in our contractual agreement with the insurance carrier. HealthQuest does not file any fees to the insurance company unless requested by patient or guardian, but if the insurance denies then the responsibility falls back onto the patient or guardian.

The terms of this contract are contingent on any contractual agreement made between HealthQuest and the insurance company in that any terms here in stated that violate the provider's contractual agreement are voided and/or nonapplicable.
By signing this form, you have read and agreed to the terms.

_____ _____/_____/_____

Patient or Guardian Signature **(relationship to patient)** **Date**

ADOLESCENT MEDICAL HISTORY

Pediatrician Name/Clinic: _____Phone #: _____
Up to date on Immunizations ❑Yes ❑ No (office will need a copy of immunization records)
Date last hearing screening _____/_____/_____ Results _____
Date last vision screening _____/_____/_____ Results _____
Has the Child/Minor ever had any of the following medical workup:
❑Broken Bones ❑Lead or other poisoning ❑Seizures ❑Head/Brain Injury ❑Loss of Consciousness ❑Head/Brain Scan ❑Hospitalizations ❑Surgery ❑Other_____
List the Child/Minor's medical problems (past and present):❑Asthma ❑Diabetes ❑High Blood Pressure ❑High Cholesterol ❑Heart Conditions ❑Other_____

DEVELOPMENTAL HISTORY

Biological mother's age at Child/Minor's birth _____ If Child/Minor was adopted, age of adoption _____
Check each box that applies: The biological mother usage during pregnancy: ❑Alcohol ❑Cigarette ❑Over the Counter medications ❑Prescriptions medications ❑Recreational/Street Drugs
List medications taken: _____
List Recreational/Street drugs taken _____
Complications during pregnancy _____
Complications during birth _____
Child premature? _____ Due Date _____How early? _____ Child birth weight? _____
Rate Child/Minor's personality from age 0 to 1 year: (check one)
❑Easy going ❑Slow to warm up to others ❑Demanding and difficult to please
At what age did your Child/Minor first start: _____ Sit UP _____Crawl
_____ Walk _____Say single words _____ Pulling UP
_____ Say 2 or more words together _____ Became toilet trained

SCHOOL HISTORY

Name of current school: _____ Grade:_____
Current placement: ❑Regular ❑Alternative ❑Special Education ❑For behavior only
❑For learning difficulties ❑Both ❑Other _____
Grades Repeated _____ Number of schools attended this year _____ # of Absences _____
How long Absences _____ Tested for placement by school: ❑Yes ❑No If yes, When: _____
Specific Educational difficulties in: ❑Spelling ❑Math ❑Reading ❑ All Subjects ❑Other _____
Current Academic Performance _____

HEALTHQUEST: Guardian Authorization

********Complete this form only if the patient is a minor or an adult dependent********

Minor/Adult Dependent Name: _____ DOB _____/_____/_____

Guardian Name: _____ DOB _____/_____/_____

I certify I am the parent or legal custodian guardian of _____, who is a minor or an adult dependent.

It is my responsibility to provide HealthQuest with the necessary legal documentation to prove such custody of minor or adult dependent.

I authorize HealthQuest to conduct an evaluation on the minor/adult dependent. Such an evaluation may include, but not limited to: personal interviews, psychological test, review of treatment records, and other generally accepted practices in the field of mental health.

I authorize HealthQuest to provide mental health treatment to the minor/adult dependent. Such treatment may include, but not limited to: individual psychotherapy, group treatment, medical management, family therapy, or specialized therapeutic procedures, which are generally accepted in the field of mental health.

_____ _____/_____/_____

Signature of Guardian **(relationship to patient)** **Date**

_____ _____/_____/_____

Witness **Date**

Place Label Here

HEALTHQUEST: Medication Information

Patient Name: _____ DOB _____/_____/_____ **List all medications you are currently taking with the dosage/strength and how many times a day you are taking the medication. Explain the reason you are taking the medication (example: diabetes, high blood pressure, depression, etc.). Please take time to fill out pharmacy information accurately.**

❑See list given by patient

Medication:	Dosage/Strength:	Frequency:	Reason for Use:

Allergies: ❑**No known allergies**

_____

_____

Pharmacy Name _____ **Phone #** _____ **Address** _____

HEALTHQUEST: Questionnaire Form

Patient Name: _____ **DOB** _____/_____/_____ **In order to give you the proper treatment and medication management, we need to know your background and history. Please complete fully and truthfully.**

Chief Complaint (what brings you here today): _____

_____

_____

Briefly describe goals of treatment you would like to achieve and/or see happen by coming here:

_____

_____

_____ **Please circle any of the problems that pertain to you:**

Nervousness	Depression	Fear
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage

List all medical problems/conditions you may have not listed above:

_____

_____

HEALTHQUEST: Questionnaire Form (continued)

Please describe any stressful events or circumstances that may trigger your mental conditions

_____

_____

Have you attempted to commit suicide? _____ how many times? _____ When? _____ How?

_____

Why? _____

Hospitalized where _____ When? _____

Do you hear voices? _____ What/Who? _____

Do you see things? _____What/who? _____

List all physicians you are currently being treated by with their specialty and phone number.

1_____

2_____

3_____

4_____

5_____

List Psychiatric Hospitals you have been admitted to with the dates and reasons.

1_____

2_____

3_____

4_____

5_____

List Psychiatric programs you have attended and/or enrolled in.

1_____

2_____

HEALTHQUEST: Questionnaire Form (continued)

Do you:

❑ Smoke How long? _____ Smoke what? _____ How often? _____

❑ Drink How long? _____ Drink what? _____ How often? _____

❑ Illegal Drugs How long? _____ What kind? _____ How often? _____

❑ Caffeine What and how much on a daily basis? _____

Are you pregnant? ❑YES ❑NO

Are you able to drive? ❑YES ❑NO **If no, who drives you?** _____

Do you have an impairment? ❑YES ❑NO **If yes please explain**_____

_____

Do you have a PSYCHIATRIC ADVANCE DIRECTIVE? ❑YES ❑NO

(If you have questions regarding this, please request information with the receptionist.)

Family members you live with? _____

_____

Describe your support system _____

_____

List your leisure interests _____

_____

Please explain if you have any difficulty with daily activities and how you cope and who helps you

_____

_____

_____

_____

Place Label Here

HEALTHQUEST: Patient Rights and Responsibility

You have the following RIGHTS:

- The right to be informed of any treatment risks that may occur or possible side effects of medication.
- The right, to the extent permitted by the law, to refuse specific treatment, procedures, or medication, unless there is danger of harm.
- The right to confidentiality.
- The right to know about any changes made to clinical staff who are directly involved with your treatment.
- The right to privacy as appropriate to your treatment setting.
- The right to be treated with respect and in a dignified way. You have a right to privacy and to have your medical and financial information treated with privacy.
- The right to ask for and get information about HealthQuest and/or your insurance carrier, its policies, its services, its caregivers, and members' rights and duties.
- The right to ask for and get information about how your insurance plan pays its providers, including any kind of bonus for care based on cost or quality.
- The rights to ask for and get information about your medical records as the federal and state laws say. You can see, get copies, and if wrong, ask for corrections on your medical records.
- The right to get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. You have a right to file a complaint if you think you have been treated unfairly. If you complain or appeal, you have the right to keep getting care without fear of bad treatment from HealthQuest, its providers, or your insurance plan.
- The right to get care without fear of physical restraint or seclusion used for bullying, discipline, convenience, or revenge.
- The right to make appeals or complaints about HealthQuest, your TennCare plan or your care.
- The right to make suggestions about your rights and responsibilities. Choose a PCP in your insurance network. You can turn down care from certain providers.
- The rights to get medically necessary care that is right for you, when you need it. This includes getting emergency services 24 hours a day, 7 days a week.
- The rights to be told in an understandable way about your care and all the different kinds of treatment that could work for you, no matter what they cost or even if they aren't covered.
- The right to make a living will or advance care plan and be told about Advance Medical Directives.
- If you are with TennCare, you can change health plans. If you are new to TennCare, you can change health plans once during the 45 days after you get TennCare. After that, you can ask to change health plans through an appeal process. There are certain reasons why you can change health plans.
- The rights to ask TennCare to look again at any mistake you think they make about getting on TennCare or keeping your TennCare or about getting your health care.
- The right to end our TennCare at any time.
- The right to exercise any of these rights without changing the way TennCare or its providers treat you.

Your willingness to actively participate in treatment plays a crucial part in achieving treatment success. Therefore, you have the following RESPONSIBILITIES:

- The responsibility to provide accurate and complete information as needed for your treatment planning.
- The responsibility to update any changes in information needed for your treatment planning.
- The responsibility to make it known whether or not you understand your treatment plan.
- The responsibility to actively participate in your treatment.
- The responsibility to indicate when you are unwilling and/or unable to comply with your treatment plan.
- The responsibility for your actions if you refuse to comply with treatment plan recommendations.
- The responsibility to follow all rules and regulations established to maintain a safe treatment environment.
- The responsibility to respect the rights and confidentiality of others.
- The responsibility for your actions if you fail to comply with appointments, with the understanding that noncompliance may lead to termination of HealthQuest services, which is determined by the HealthQuest provider.

_____ _____

Print Name **Signature**

Date: _____

HEALTHQUEST: Verification of Notice of Privacy Policy

I, _____ agree that I have been given a copy of HealthQuest's

Print Name

Notice of Privacy Practices.

_____ _____

Patient signature or Guarantor **Date**

_____ _____

Witness Signature Date

For Office Use Only

If signature was not given, please provide efforts in attempting to obtain signature:

_____

_____

_____

_____

_____

_____

_____

_____

HealthQuest: Behavioral Health Consent for 16 and 17 year olds

Records and information relating to the mental health of an individual are confidential and privileged to the patient, and may only be disclosed in accordance with the statute.

A patient, if he or she is over the age of 16, may consent to the disclosure of information relating to their behavioral health.

❑ I do not want to share my information with my parents/guardians.

❑ I do want to share my information with my parents/guardians.

_____

Print Name

_____ _____

Signature **Date**

HealthQuest: Primary Care Physician Release

Patient Name:_____ DOB:_____

To be completed by patient:
Primary Care Physician:_____ Phone#:_____

Address:_____
Street City State Zip

Communication between behavioral health providers and primary care physicians is important to help ensure that all patients receive comprehensive and quality health care. This information is not release without the patient's consent. This information may include diagnoses, treatment plan, and medication, if necessary.

Below please find the consent or refusal to release said information. The patient may revoke this consent at any time (in writing) except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

To be completed by HealthQuest provider:

This patient was seen at our office for mental health treatment as a result of:

❑ Direct patient call to our office
❑ Post A/D inpatient admission
❑ Referral from PCP
❑ Referral from insurance company
❑ Post psychiatric inpatient admission
❑ Other_____
❑ Current patient at HealthQuest

Diagnosis given:

Medications given:

❑ Medication Management

❑ Referral to _____ for_____

❑ Other_____

Patient was last seen by me on:_____, _____
Date Provider

58 Timber Creek Dr.
Cordova, TN 38018
(901) 566-1002

HealthQuest: Informed Consent for Psychotropic Medication

Medication: Generic/Brand Name	Dosage/ Strength:	Frequency:	Reason for Use:	Route:

Information about the use of the medication(s) was provided ORALLY as part of this consent by:

_____ _____ _____❑AM

Name of Person Providing Information **Date** **Time** ❑PM

Information was delivered:

❑ in face-to-face conversation

❑ by telephone

Person giving informed consent, check all boxes that are true:

❑ I understand the information above that has been explained to me about the psychotropic medication(s) listed.

❑ I was given the same information in writing.

❑ I understand that I may refuse consent.

❑ I understand that my consent may be withdrawn at any time.

❑ I understand that the consent is time limited and expires annually.

Based upon the information provided, check the one box you agree with:

❑ I approve the use of psychotropic medication(s) listed.

❑ I do not approve the use of psychotropic medication(s) listed.

❑ I only approve as specified in my written comments

Comments: _____

_____

Print Name

_____ _____

Signature **Date**

FOR YOUR SAFETY

HealthQuest

We are so happy to have you with us at HealthQuest. We want your experience with us to be enjoyable and safe. We want to share the following "FOR YOUR SAFETY":

"FIRE!" "FIRE!"

If you smell or see smoke or actual flames, DON'T try to put it out yourself! Tell the closest staff member. There is a fire extinguisher in the breakroom and less than 50 feet from you in any direction. You are sake. The exits are clearly marked at both ends of the hall. Calmly exit from the building toward the nearest exit away from the fire. A staff member will pull the fire alarm located at the building's exit or entrance doors and man the fire extinguisher. Again, DON'T attempt to put out the fire yourself.

INCLEMENT WEATHER

In the event of inclement weather the determination of our closing will be made based on road conditions, power outages, and other safety issues. This determination may or may not be consistent with local schools. Please call the facility at; (901) 566-1002 when the weather is questionable.

DISASTER RESPONSE

Should these be a community emergency caused by natural disaster, civil disturbance, terrorist activity, or other disruptions, will take our cue from the prompting of the police department and civil defense organizations. As long as it is safe to do so, we would hope to provide services. If a natural disaster or other emergent event takes place during service hours, groups would be disbanded and the client would be permitted to return to their homes unless it would be unsafe for them to leave at the time.

Should a tornado or other weather alert be sounded making it dangerous for the client to leave the building at the time, all persons in the building would group in the innermost portion of the hall. All doors would be shut. The Administrator would guide the group's decision as to when the danger has lifted.

_____

Printed Name

_____ _____

Signature **Date**

HealthQuest: Patient Rights

1. Each patient and each patient's family or guardian will be treated with consideration, dignity, and respect.
2. All patients have the right to be protected from physical, verbal, and emotional abuse (including corporal punishment), and from all forms of exploitation.
3. Patients are admitted and treated without regard to age, race, creed, gender, or national origin.
4. Each patient, or the patient's legal guardian, will have the right to view and ask that a copy be made of the evaluative reports or other contents in his/her chart.
5. All patient records and all communications, whether written or oral, are strictly confidential and will not be disclosed without the patient's written consent or the written consent of the patient's legal guardian.

There are four major exceptions to this rule of strict confidentiality:

- The clinic will disclose confidential information to the Department of Human Services and/or county or municipal authorities if the clinic has good reason to believe that a patient has been abused or is in imminent danger
- The clinic will disclose confidential information to patients or legal guardians and/or county or municipal authorities if the clinic has good reason to believe that a patient has been abused or is in imminent danger.
- The clinic will disclose confidential information to representatives of state and federal agencies as required by state and federal rules and regulations.
- If clinic records are subpoenaed by law (against patient's wishes or the wishes of legal guardian of the patient) the clinic will oppose the subpoena, but the court will itself decided on the merits of the disclosure.

6. If the treatment prescribed by the clinic that may be potentially hazardous to the patient, then that treatment must be fully discussed with the patient so that the patient has the right to refuse such treatment.

7.The patient/patient's family who feel their rights have been abused are encouraged to follow the grievance process and call in to complain to the Administrator: 901-566-1002 and if not resolved to the West TN Complaint Intake of the Department of Mental Health and Developmental Disabilities Office of Licensure (1-866-344-0858)

8. Patients have the right to voice grievances to staff of a facility, to the license, and to outside representation of their choice with freedom from restraint, interference, coercion, discrimination, or reprisal.

9. Each patient has the right to communicate with family, friends, legal representatives, and significant others as he/she might desire. No patient may be "held" by the clinic. The clinic itself does not include hospital (inpatient) or residential services.

10. If a clinic patient, or family member is chosen as a potential research participant, the patient, or legal guardian, must give written informed consent before undergoing any research procedure.

HealthQuest: Patient Rights

❑ I have received a copy of Patient's Rights and Responsibilities

❑ These rights were explained to me and I was given the opportunity to ask questions.

❑ I do understand my rights as presented.

❑ I have been informed that if my rights have been violated, and/or I have concerns for my care or safety, I can contact the Administrator of HealthQuest. If this does not satisfy or remedy the complaint, I can then contact the Tennessee Department of Mental Health and Disabilities Office of Licensure and the Joint Commissions Office of Quality Monitoring.

_____

Print Name

_____ _____

Signature **Date**

_____ _____

Witness **Date**