CONTINUUM INTEGRATED

PATIENT RIGHTS AND RESPONSIBILITIES

We consider you a partner in your treatment. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your visit as effective as possible. We encourage respect for the personal preference and values of every individual.

As a patient of Continuum Integrated you have the RIGHT to:

- Personal privacy and confidentiality of information.
- Receive reasonable access to care and response to requests and needs for treatment or service, within the centers' capacity, its stated mission and applicable law and regulation.
- Consent to or refuse treatment. If you refuse the recommended treatment, you will be informed of the medical consequences other needed and available care.
- Right to request or seek a second opinion.
- Receive at the time of admission, information about Continuum Integrated patient rights policies.
- Have your special communication needs met through the best efforts of the center.
- Care that is considerate and respectful of your personal values and beliefs.
- Appropriate assessment and management of pain.
- Participate, with your physician, in your active treatment plan.
- Request advance directives in accordance with the law.
- Participate in ethical issues that may arise in the course of your care.
- Receive care in a safe setting and be free from all forms of abuse, harassment or neglect.
- Be free from the use of seclusion or restraint, unless clinically necessary and used only as a last resort, in the least restrictive manner possible.
- Expect that treatment records are confidential unless you have given written permission to release information or reporting is required as permitted by law.
- Access information contained in your clinical record within a reasonable time frame and scope or policies.
- Receive information about clinical experiments, research or educational projects affecting your care or treatment including the expected benefits, potential discomforts and risks and alternatives that may also be available.
- Consent or decline to take part in research affecting your care.
- Know about rules and regulations applicable to patient care and conduct that affect you and your treatment.
- Request and receive a detailed explanation of your bill.
- Not to be subjected to discrimination or reappraisal for exercising rights
- Have your guardian, next of kin or legally authorized responsible person exercise, to the extent permitted by law, your patient rights.
- Not to be asked to performed services for the center and to be paid by the center for any work.
- Be informed of the complaint/grievance process. You may voice complaints or concerns, without affecting your care or treatment, the grievance committee or by contacting the

Texas Department of Health 1-800-228-1570 or write to 1100 West 49th Street Austin, Texas 78756-3199	Texas Department of Insurance HMO Complaint Help 1-800-252-3439 In Austin, call 463-6515 Servicio en Español	Office of Quality and Patient Safety The Joint Commission patientsafetyreport@jointcommission.org Ph: (630)792-5800 One Renaissance Boulevard Oakbrook Terrace, Illinois 60181

As a patient of Continuum Integrated you have the RESPONSIBILITY of:

- Providing information about your health, including past illness, hospital stays, use and names of medicines you are or have been taking whether prescribed or over-the-counter.
- Asking questions when you do not understand information or instructions.
- Telling your doctor, if you believe you cannot follow through with your treatment.
- Being considerate of the needs of other patients, staff and the clinic.
- Assisting in the control of noise, cell phone use and the number of visitors.
- Being respectful of the property of others.
- Providing evidence of financial responsibility and only when authorized working with the clinic to arrange payment, when needed.

Our practice serves many purposes. Continuum Integrated works to improve people's health, give treatment to their health, educate doctors, health professionals, patients and community members; and improve understanding of health and treatment. In carrying out these activities, this organization works to respect your values and dignity.

________________________________ **Patient/Parent Signature**   __________________ **Date**

________________________________ **Witness**   __________________ **Date**

_Copy given to Parent/Guardian   **__Parent/Guardian refused copy**

INFORMED CONSENT

CONFIDENTIALITY
I understand that all information between me and my therapist is held strictly confidential, and my therapist will not release any information about my therapy unless permitted by law or:

1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3 A subpoena for your records from the court system,
4. I present a danger to others,
5. Child/elder abuse/neglect is suspected.

I understand that in the latter 2 cases, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

RELEASE OF INFORMATION
In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other health care providers and facilities for purposes of diagnosis and treatment. I further authorize the release of information for claims, certification/case management/quality improvement and other purposes related to the benefits of my Health Plan. [Releases of information to providers, family, etc. require separate form.]

FINANCIAL TERMS
Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my Provider will be paid directly by the carrier. I will be responsible for any applicable deductibles and co-payments. I agree to make these payments at each appointment. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. If I am without health plan/insurance coverage, payment arrangements will be made prior to my first visit.

APPEALS AND GRIEVANCES
I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) are denied certification (Appeal). I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a Grievance to the Provider or the Administrator any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the Grievance to my insurance company directly.

CONSENT FOR TREATMENT
I further authorize and request that qualified, licensed providers carry out my evaluation(s) and treatment now or during the course of my patient care. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I also understand that my treating psychotherapist, psychologist, or psychiatrist is a licensed, qualified and credentialed mental health professional.

CANCELLED/MISSED APPOINTMENTS
I understand that if an appointment is missed or canceled with less than 24 hours' notice, I will be billed according to the scheduled fee or according to the rules of my health plan. Repeated no show appointments @ (two or more) could result in suspension of mental health services, pursuant to the disclosure form and evidence of coverage. If I no show or late cancel twice, I understand that I may have to wait for a future appointment or be placed on the waiting list and depending on my health plan may be required to pay for the session that is canceled or missed..

____ ______________________
Print Name (or Parent/Guardian) Date

____ ______________________
Patient Signature (or Parent/Guardian) Date

__Copy given to Parent/Guardian **__Parent/Guardian refused copy**

PATIENT CONSENT FOR TREATMENT
(for Child/Teen only)

I, ________________________________, hereby give my full consent for my child/teen,________________________________, or myself to receive services from Continuum Integrated. I will notify Continuum Integrated of any changes immediately as they occur or until it is determine that services are no longer necessary. If I am referring my child/teen for behavioral healthcare services, I certify that I have legal responsibility for this child/teen, and I am authorized to seek treatment for him/her.

I understand that Continuum Integrated *is* behavioral healthcare organization that is comprised of physicians, psychologist, social workers and counselors who work together as a team to provide behavioral healthcare. Professionals have separate appointments depending on the needs identified during individual and family sessions.

I understand that there is an expectation that I/we will benefit from the services provided, but there is no guarantee that this will occur. There is also no guarantee regarding the duration of treatment. I understand that my sessions may deal with disturbing and difficult topics may elicit uncomfortable emotions and may lead to individual decisions that may be temporarily disturbing for me and my family. I also understand that all information disclosed within my session is confidential and will not be revealed to anyone outside the supervising team without written permission unless required by law or necessary to comply with the requirements of accrediting agencies. Disclosure may be required by law: (1) when there is a reasonable suspicion of abuse/neglect to a child/teen, dependent or elder adult; (2) when the patient communicates a threat of bodily injury to self or others; or (3) when disclosure is required pursuant to a legal proceeding.

I understand that I have the right to refuse services and to discontinue services at any time. Also Continuum Integrated may discontinue services for the following reasons: 1) the goal(s) of treatment has been successfully achieved, 2) two consecutive missed appointments without notification, 3) three missed appointments without notification within 60 days or 4) no contact with the therapist within 30 days after last appointment. I understand that I will be financially responsible for any court reports, appearances or consultations that are required in association with the treatment received.

AUTHORIZATION TO SIGN ON BEHALF OF A MINOR

Where the child/teen's biological parent is not married (separated, divorced, etc.) or custody is legally held by another person(s), a document showing authority to act on the child/teen's behalf is required by regulation to be filed in the patient's chart.

I, ____, confirm that I am (*please check one)*:
☐ The biological or adoptive parent having legal custody generally since birth, i.e., not separated or divorced (no need to provide legal documentation); or

The following must provide legal documentation:

☐ The managing conservator; or
☐ Other legal guardian and have been granted guardianship by the court or biological parents.
Please describe type:
____

Signature of Parent/Guardian: ____ **Date:** ____________________________
Signature of patient (16 yrs. and older): ______________________________ _ **Date:** ____________________________
Witness: ____ _ **Date:** ____________________________

I acknowledge that I have read and/or received a copy of *CONTINUUM INTEGRATED's* "Notice of Privacy Practices."
☐ Yes (You are welcome to ask the receptionist for a paper copy to take with you.)
☐ No Please describe reason:
____

CONTINUUM INTEGRATED

NEW PATIENT INFORMATION

Hours – Outpatient appointments are available Monday through Friday 9:00 AM to 6:00 PM. Saturday appointments are available until 3:00 PM and by appointment only. Treatment Program such as Intensive Outpatient Programs, Partial Hospitalization Programs, and Telehealth Sesions have separate schedules which may be obtained from medical assistants.

Emergency Number -The office number (713) 383-0888 is answered 24 hours a day either by the office staff or by our answering service after hours or when the office is close for meetings.

Weather Warnings - In the event severe weather occurs, as reported by the major television networks, adjustments in patient schedules may occur automatically. We ask that patients/guardians call the 24 hour number to determine if the office has been closed.

Appointments/Cancellations - We require that you notify our office of cancellations no later than ***the business day before your appointment.*** Depending upon the presence of prior "Cancellations" and/or "No Shows" patients may be offered a work-in period of time until a consistent pattern compliance has been demonstrated.
In anticipation of missed appointments, patients must communicate with the treatment provider prior to the occurrence, preferably 24 in advance.

Proof of Coverage or Financial Eligibility – Proof of coverage must be provided prior to the first appointment. Patients who require monthly renewals of insurance coverage must provide proof of eligibility prior to the first appointment of a new month. In all instances, staff must establish the existence of coverage prior to an appointment with any treatment provider.

Payment - Co-payment is expected at the time of service to demonstrate commitment to improving your health. We accept many major medical insurers, and we will bill your insurance carrier for you, however, if your claim is denied, it becomes your full responsibility to pay for services. A credit card payment option is available upon request.

Patient or Responsible Party Agreement: I/we have:
1. Read and understand this New Patient Information.
2. Agree to the provisions stated herein.
3. Consent to the release of appropriate treatment information to the primary care physician referring doctor or, professional, insurance company or other third party paying for services.
4. Authorize payment of medical benefits directly to **Continuum Integrated**.

____ ______________________
Signature of Patient, Parent or Guardian Date

CONTINUUM INTEGRATED

PATIENT CONSENT FOR DISCLOSURES

Primary Language: **Patient- English** **Spanish**
Parent- English **Spanish**

In General, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication made by alternative means, such as sending correspondence to individual's office instead of the home.

Home Telephone ( )______________________
Cell Number ( )______________________

____OK to leave message with detailed information
____Leave message with callback number only

Work Telephone ( )______________________

____Ok to leave message with detailed information
____Leave message with callback number only

Written Communication
___Ok to mail to my home address
___Ok to mail to my work/office address
___Ok to fax to this number ( )________________

E-mail address ________________________________
___Ok to send documents
___Ok to send message

________________________________ ____________________
Patient/ Parent Signature Date

________________________________ ____________________
Print Patient/Parent Name Patient Date of Birth

Authorized persons that can act on my behalf:

______________________________ ____________________ ( )_________________
Print Name Relationship Contact Number

______________________________ ____________________ ( )_________________
Print Name Relationship Contact Number

Patient's Name: _______________________ DOB: _______________ Date: ______________

SAFETY AND QUALITY OF CARE STANDARDS

We highly recommended that the number of visitors be limited when in this treatment environment. Signs are placed in the waiting room(s) to help us to respond to our quality of care and safety concerns. If we find it necessary, we will advise patients, parents or guardians of our concerns about the risk we observe in the environment. If the need occurs to respond to uncontrolled or high risk behaviors, staff will be professional and interested only in the well-being of our patients and visitors.

Examples of risks to safety and quality include:
Unaccompanied children (16 or younger) are prohibited from walking around or wandering around anywhere in this business building. Children and adults who leave the waiting room to sit outside our doors or anywhere on the 4th floor are considered a safety hazard by building management.

Risk of injury or destruction of property may occur when additional children are brought to the office. We ask that parent(s) bring only patients to the facility unless requested.

Risk of injury or destruction of property occurs when over-active or uncontrolled behaviors exists while waiting. Injury to any child or adult is unwanted and we believe that we are all responsible for maintaining a low risk and safe environment of care.

Inappropriate or Disruptive Waiting Room Behaviors
We do not tolerate threatening or aggressive behaviors in our waiting room from patients, parents, guardians, visitors or staff. Management staff will respond to statements unbecoming to a calm, orderly and pleasant environment. A discharge from treatment may be swiftly done and services will be terminated. If necessary we will contact police to have patients or visitors removed by the appropriate authorities.

Inappropriate Telephone Behavior
We do not tolerate inappropriate, demanding or threatening communication from patients, parents or guardians. Our telephones are usually very busy. When frustrations weigh heavily upon you concerning any issue(s), we strongly recommend that you talk privately with the assigned therapist during your next appointment. If repeated incidents of inappropriate telephone behaviors are reported, discharge from services may occur.

I have read and understand that repeated incidents of inappropriate or disruptive behaviors may lead to discharge from treatment.

____ ____

Parent Signature Date

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NOTICE OF PRIVACY PRACTICE AND ACKNOWLEDGEMENT

I understand that in accordance with the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your NOTICE OF PRIVACY PRACTICE containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICE from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICE.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (print):_____________________________ DOB:__________________________

SIGNATURE:___________________________________ DATE:_________________________

Relationship
To Patient: Self Parent Legal Guardian
Other______________________

If patient is minor:
Parent or Guardian ***PRINT***
NAME:____

____
__

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this notice of Privacy Practices Acknowledgement, but was unable to do so as document below:

Reason:____ Date:_________________
Initials:_______

CONTINUUM INTEGRATED

MEDICAL REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date: ____

Patient Name:

____
Last Name First Name Initial

Address:____

City: ________________ State: ________ Zip: ___________

Home(_____)____

Cell Phone (_____) _________________________________

Work (_____)_______________________________________

Primary Language:__________________________________

Sex: ☐ M ☐ F Age:_____ Date of Birth: ______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient's SSN: ___________________________________

Occupation: ______________________________________

Patient's Employer/School:___________________________

Whom may we thank for referring you? _________________

PARENT/ GUARDIAN OR NEXT OF KIN:

Name:____
Last Name First Name Initial

Phone: ____

Relationship: ______________________________________

IN CASE OF EMERGENCY CONTACT:

Name:____

Relationship: ______________________________________

Home (_____) _____________________________________

Cell Phone (_____) _________________________________

Work Phone (_____)

____

2. INSURANCE INFORMATION

Who is responsible for this account? _________________

Relationship to Patient:_____________________________

Date of Birth: _____________ SSN#: _________________

Insurance Company:_________________________________

Policy I.D.#: ______________________________________

Group #: ____

Is the patient covered by additional Insurance? ☐ Yes ☐ No

3. PRESENTING PROBLEM (This section must include the reason for the visit in your own words)

Presenting Problem: ________________________________

____

____

____

____

____

4. MEDICATIONS/ALLERGIES

List medications the patient is currently taking:__________

____

____

____

____

Pharmacy Name: ___________ Phone (____) __________

List allergies to medication or substances: _____________

____

____

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5. MEDICAL HISTORY (Check ✓ symptoms the patient currently has or have had in the past year) (All information is strictly confidential)

GENERAL
- ☐ Fatigue
- ☐ Coughing
- ☐ Dizziness/Fainting
- ☐ Chronic Fever
- ☐ Unexpected Weight Gain
- ☐ Headache
- ☐ Unexpected Weight Loss
- ☐ Loss of Sleep
- ☐ Wheezing
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Heartburn
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Stomach Pain
- ☐ Excessive Thirst
- ☐ Vomiting Blood
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Rectal Bleeding

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred Vision
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Ear Discharge/Ache
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems

MEN ONLY
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Other

WOMEN ONLY
- ☐ Extreme Menstrual Pain
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Other

Date of Last Menstrual Period ___________________

Date of Last Pap Smear ___________________

Have you had a Mammogram _______________

Method of Contraception:
____

MUSCULOSKELETAL

Pain, Weakness, aching or swollen
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Joints ☐ Muscles

GENITO- URINARY
- ☐ Bed- Wetting
- ☐ Frequent Urination
- ☐ Painful Urination

NEUROLOGICAL
- ☐ Numbness
- ☐ Paralysis

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Irregular/Rapid Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

SKIN
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that will not heal

Check ✓ conditions the patient currently has or has had in the past

☐ AIDS	☐ Chicken Pox	☐ HIV Positive	☐ Polio
☐ Appendicitis	☐ Diabetes ☐ Type I ☐ Type II	☐ Kidney Disease	☐ Prostate Problem
☐ Arthritis	☐ Emphysema	☐ Liver Disease	☐ Rheumatic Fever
☐ Bleeding Disorders	☐ Epilepsy	☐ Measles	☐ Scarlet Fever
☐ Breast Lump	☐ Glaucoma	☐ Migraine Headaches	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Cataracts	☐ Hepatitis	☐ Mumps	☐ Tuberculosis
☐ Asthma	☐ Herpes	☐ Pacemaker	☐ Ulcers
☐ Chemical Dependency	☐ High Cholesterol	☐ Pneumonia	☐ Venereal Disease
☐ Depression	☐ Edema	☐ Mood Swings	☐ Anxiety
☐ AD/HD	☐ Bipolar Disorder	☐ Stress Disorder	☐ Iron Deficiency
☐ Sickle Cell Anemia	☐ Irrational Beliefs	☐ Other: ____________________________	

☐ Suicide Attempt (s) (When____

☐ Hospitalization (s) (When/Reason ____

Are you currently seeing a physician for any of the above problems? ☐ Yes ☐ No:____________

Are any of the above health concerns currently not adequately being addressed by a physician? ☐ Yes ☐ No

Date of your last physical exam or doctor's appointment: ________________________

In the last 6 months have you had any significant medical treatment or procedures? ☐ Yes ☐ No:

Have you ever had a minor or major brain injury (concussion, blackout(s)? ☐ Yes ☐ No

Does you smoke? If Yes, how much? _________ Do you drink alcohol? If Yes, how much and how often ________

Have you signed an advanced directive, such as a living will or durable power of attorney for health care? ☐ Yes ☐ No

If Yes, where is it located? ____

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6. SOCIAL ENVIRONMENT

Person Completing Form:______________________ ___Relation: Self or Parent/Guardian:______________________
Primary Care
Doctor/Pediatrician:____
Other Doctor(s) treating You :____

(1) The Family--- list yourself and all members living in the home including your child:

Name	Sex	Age	Place of Work or School
______________________________________	_____	_______	__________________________________
______________________________________	_____	_______	__________________________________
______________________________________	_____	_______	__________________________________

(2) If there have been any separations or divorces, give date(s), name(s) of other involved figures. If any children, list which parent(s) have legal and which have physical custody: _______________________________________

(3) Family members not living with you (for example, grown children, boyfriend, parents):_______________________

(4) Are there any family members (parents, siblings, grandparents, aunt, uncles or cousins) who have emotional and mental health, or substance abuse difficulties (include behavior, school or work problems, seizures/epilepsy)?____

(5) Have you or anyone in your family ever seen a counselor or doctor for emotional, mental health or substance abuse difficulties? If Yes, who and when: ____

(6)Have you or anyone in your family ever taken any medications for emotional, mental health or substance abuse difficulties? If Yes, who and when:
____
____

(7)Have you or anyone in your family ever been in a hospital for emotional, mental health, or substance abuse difficulties? If Yes, who and when:____
____

(8) Have you or anyone in your family ever attempted suicide?____

(9) How do you get along with others in the family?____

(10) How do you do at work?____ ____

(11) What other things would be helpful to know about you or your family? ____________________________________

7. SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in health, address, or insurance coverage.

____ _________________________
Signature of Patient Date

____ _________________________
Please Print Name of Patient Relationship to Patient

____ _________________________
Reviewed for Completion by (Staff) Date