COMMUNITY PARTNERS
OF SOUTH FLORIDA
HEALTH | HOUSING | COMMUNITY

Intake Packet Signature Page

Client Name:_____ MR#_____

Handbook Policies:

- ☐ Client's Rights & Responsibilities
- ☐ Missed Appointment Policy
- ☐ Reporting of Missing Children
- ☐ Grievance Procedure
- ☐ Human Rights Advocacy Committee
- ☐ Notice of Privacy Practices
- ☐ Financial Policy
- ☐ Written Statement of Purpose for Collection of Social Security Numbers

By signing below I acknowledge that I have received a copy of *Community Partners of South Florida (CPSFL) Client Handbook.* I have been given an opportunity to read the above policies and information, which are in the Handbook, and ask my practitioner questions about any policy.

Consent for Treatment:

By signing below, I give consent for the staff of *Community Partners of South Florida (CPSFL)*, Inc. to administer treatment. I understand that CPSFL is a training site for a variety of professional students and that a student, trainee, or Registered Intern, under the supervision of a licensed professional, may provide some services. I understand that no guarantee or assurance is being made to the results that may be achieved. Additionally, I have the right to refuse treatment at any time.

_____ _____
Client Date

_____ _____
Parent/Guardian if the client is under age 18 Date

_____ _____
Witness Date

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MEDICAID/PHP BILLING AUTHORIZATION

Client Name:_____DOB:_____MR #: _____
Last First

This will authorize *Community Partners of South Florida (CPSFL)* to release general medical, as well as psychiatric/psychological information, from my health records in accordance with Florida Statutes 90.242, 490.32 and or 458.16 and 458.21 to MEDICAID and PHP.

A general medical authorization and subpoena duces tecum, without a specific authorization to release psychiatric/psychological information must have this waiver from the patient or his/her empowered representative.

Record to be used for MEDICAID/PHP billing.

I understand that I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release of the information requested.

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

This authorization will be valid for the duration of services at this facility for the purposes of providing information to the MEDICAID/PHP office for payment of the liability incurred by this patient and family.

_____ _____
Client Date

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

Community Partners of South Florida (CPSFL) Client Handbook

CLIENT RIGHTS & RESPONSIBILITIES

INDIVIDUAL DIGNITY: The client and family will be treated with respect and courtesy. The agency does not discriminate in the manner in which it provides services. No person is denied services based on color, race, religion, sexual orientation, national origin, gender or income. All services are voluntary and the organization's policy and procedures ensure that consumers served may refuse any service, treatment, or medication, unless mandated by law or court order. No member, regardless of their disability, is refused services. They will be informed about the reason for treatment, benefits, common side effects, alternatives and approximate length of treatment.

PARTICIPATE IN TREATMENT & DISCHARGE PLANNING: The client may agree to or refuse treatment, as permitted by law. The client will receive individualized treatment in the least restrictive setting. The client may participate in all treatment and discharge planning and the evaluation of services.

QUALITY TREATMENT: Competent professionals will provide treatment to all persons served by the agency.

EXPRESS AND INFORMED CONSENT: Express and informed consent for admission and treatment of a minor client will be required from the guardian. The client or guardian may revoke consent at any time.

CONFIDENTIALITY: Clinical records are confidential and stored in secure places. Client information will not be disclosed without written permission, unless reporting is required by law. Information may be released to protect a client form self-harm or a threatened individual.

ACCESS TO RECORDS: The client and guardian have the right to review their records, unless prohibited by law, or deemed harmful to the person.

PAYMENT INFORMATION: The client and guardian have the right to know about charges and payment methods.

COMPLAINTS AND GRIEVANCES: The client and guardian have the right to file a formal complaint by utilizing the agency's Grievance Procedure, which is part of this Handbook. If a client with a disability or their guardian feels that their rights have been violated, they may also contact the Disability Rights Florida at 1-800-342-0823, or 1-800-346-4127 (TTY/TDD), or US Department of Health & Human Services Office of Civil Rights at 1-800-368-1019 or TDD 1-800-537-7697 or Florida Communication Human Relations 1-850-7082.

CLIENT AND GUARDIAN RESPONSIBILITIES: The client and guardian are responsible for providing accurate and complete information about the client. The client and guardian are responsible for asking questions when information/instructions are not understood. The client and guardian are responsible for participating in treatment. They will notify the professional if they cannot or will not follow the treatment recommendations, and if they are unable to keep a scheduled appointment.

BEHAVIOR MANAGEMENT: *Community Partners of South Florida (CPSFL)* does not employ any behavior management practices that restrict or limit a client's freedom of movement, such as isolation, restraint, or seclusion. CPSFL promotes a healthy environment and culture that focuses on healing and is characterized by mutual respect between staff and clients.

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MISSED APPOINTMENT POLICY

In order to provide quality services for as many families as possible, the following policy will be enforced regarding failed appointments:

A failed appointment is defined as a scheduled appointment that is missed, without notice being given to Community Partners of South Florida (CPSFL) twenty-four (24) hours in advance of the appointment time. Also, clients who arrive more than fifteen (15) minutes after the scheduled appointment time may be considered to have failed that appointment.

Any client who has failed two scheduled service appointments within a program will be staffed with the CPSFL treatment team for termination of services.

When scheduling an appointment, please be sure that the time is convenient to all family members concerned and transportation is available.

REPORTING OF MISSING CHILDREN

Community Partners of South Florida (CPSFL) is committed to instruct all caregivers (including relatives and non-relatives) to immediately do the following, as applicable, and document their attempts upon discovering that a child in their care is missing:

If urgent circumstances exist and immediate action is required:

(1) Call local law enforcement as soon as the determination is made that the child is missing and ask the officer to:
   (a) Take a report of the missing child.
   (b) Assign a case number and provide the number back to the caregiver or person reporting the child missing.
   (c) Provide a copy of the law enforcement case report, when it is available.

(2) If the responding law enforcement officer refuses to take a missing child report, for any reason, request the officer's name and specific local law enforcement agency name. Immediately contact the child's service provider at CPSFL to report this information. The service provider will report this information to the Florida Department of Law Enforcement Missing Children's Information Center contact person in the district who will contact FDLE to request assistance in obtaining the missing child report.

If urgent circumstances do not exist:

(1) Within the first hour, check to see what, if any, of the child's personal belongings are missing or if the child left a note.

(2) Call the following persons to ascertain if the child has been seen, or has given any indications that may explain the child's missing status
   (a) School/child's teachers;
   (b) The child's relatives/parents who live in the geographical area, if appropriate;
   (c) Any friends or places that the child generally frequents, the local runaway shelter (if there is one in the community); and,
   (d) The child's employer, if applicable.

(3) Write down any information gathered that might help locate the child.

(4) Provide telephone numbers and ask for the individuals above to call back and share information if they have further information or see the child.

(5) Write down what the child was wearing the last time the child was seen and obtain a recent photo.

If at any time the child returns, all law enforcement agencies and other agencies notified that the child was missing must be contacted immediately. If at any time new information is obtained on the child's location, all law enforcement agencies and other agencies notified that the child was missing must be contacted immediately and appropriate efforts taken to return the child home.

***Urgent Circumstances** means situations that require immediate actions, such as the child is under the age of thirteen, believed to be out of the zone of safety for their age and development, mentally incapacitated, in a life threatening situation, in the company of others who could endanger their welfare or is absent under circumstances inconsistent with their normal behaviors.

GRIEVANCE PROCEDURE

Anytime you or your parent/legal guardian thinks that an action taken by a *Community Partners of South Florida (CPSFL)* employee is unjust, or you believe that you are being treated unfairly, you have the right to make a complaint. This complaint is called a *grievan*ce.

To file a grievance, you must proceed as follows:

1. Try to work out your differences with your case manager, therapist, or other staff. If you cannot do this to your satisfaction, they will refer you to his/her supervisor and you may file a formal written complaint.
2. Write your complaint on a plain sheet of paper, stating all of the facts and give it to CPSFL Quality Improvement Department. The Quality Improvement Department can be reached at (561) 841- 3500.
3. Within fifteen (15) days after you have given your complaint to the Quality Improvement Department, we will discuss the complaint with you and your parents/legal guardian and try to reach an agreement or a solution. You will receive a letter stating the actions taken in regard to your complaint and will also state the resolution as agreed upon by the Quality Improvement Department, you and your parent/legal guardian.
4. If, for any reason, you are not satisfied with the outcome of your grievance, you may file an appeal. Your appeal must be in writing, and given to the Chief Operating Officer within fifteen (15) days of the receipt of the response letter. Your appeal will be reviewed by the Continuous Quality Improvement Committee and the Chief Operating Officer. You will receive a written response from the committee within (ten) 10 business days.

NO ACTION WILL BE TAKEN AGAINST YOU FOR FILING A GRIEVANCE.

HUMAN RIGHTS ADVOCACY COMMITTEE

Your Rights While Receiving Services in Florida

- Right of Individual Dignity
- Right to Express and Informed Consent
- Right to Communication, Abuse Reporting and Visits
- Right to the Care and Custody of Personal Effects
- Right to Vote in Public Elections
- Right to Education for Children
- Right to Participate in Treatment and Discharge Planning
- Right to Treatment
- Right to Quality Treatment
- Right to Vote in Public Elections
- Right to Ask for a Court Order
- Right to Clinical Records
- Right to Designate Representatives

US Department of Health & Human Services Office of Civil Rights
1-800-368-1019 OR 1-800-537-7697 (TDD)

Disability Rights Florida
1-800-342-0823 OR 1-800-346-4127 (TTY/TDD) www.disabilityrightsflorida.org
Disability Rights Florida is a non-profit organization providing protection and advocacy services in the State of Florida.

– Their mission is to advance the quality of life, dignity, equality, self-determination, and freedom of choice of persons with disabilities through collaboration, education, advocacy, as well as legal and legislative strategies.

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective Date of this Notice and Policy: April 14, 2003

1. **PURPOSE:** *Community Partners of South Florida (CPSFL)* and its professional staff, employees, and trainees follow the privacy practices described in this Notice. CPSFL keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. WHAT ARE TREATMENT and HEALTH CARE OPERATIONS?
Your treatment includes sharing information among mental health care providers who are involved in your mental health care services. For example, if you are seeing both a physician (psychiatrist) and a psychotherapist, they may share information in the process of coordinating your care. Treatment records may be reviewed as part an on-going process directed toward assuring the quality of Agency operations. Staff members designated by the Quality Improvement Committee may access clinical records periodically to verify that Agency standards are met.

3. HOW WILL THE *Community Partners of South Florida (CPSFL)* USE MY PROTECTED HEALTH INFORMATION?
Your personal record will be retained by CPSFL for approximately seven (7) years after your last clinical contact. After that time has elapsed, your practice records will be erased, shredded, burned or otherwise destroyed in a way that protects your privacy. Copies of service records that have been distributed to other entities may continue to exist and be managed by their policies.
Until the records are destroyed they may be used for the following purposes unless you request restrictions on a specific use or disclosure:

- Appointment reminders and notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law);
- Mental health oversight activities, e.g., Audits, inspections or investigations of administration and management of CPSFL
- Lawsuits and disputes;
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred in the practice; when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety;
- To carry out mental health services and through transcription and billing services;
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities;

- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- *Psychotherapy notes* that are kept separate from the record enjoy special protection and require authorization for release, with certain exceptions.
- *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of supportive housing services furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.
- Alcohol and drug abuse information has special privacy protections. CPSFL will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client's substance abuse mental health services unless: (i) the client consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

4. **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES**. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

5. **YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**.
You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by CPSFL

- ***Right to request restriction***. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency mental health services.
- ***Right to confidential communications***. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- ***Right to inspect and copy***. You may have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by CPSFL. The Community Partners of South Florida (CPSFL) will comply with the outcome of the review.
- ***Right to request clarification of the record***. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. You may ask for a form for that purpose and the form will require certain specific information. CPSFL is not required to accept the information that you propose.
- ***Right to accounting of disclosures***. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for mental health services or health care operations in the last eight (8) years, but not prior to April 14, 2003.
- ***Right to a copy of this Notice***. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may print out a copy of this notice from any clinical website we provide.

6. **REQUIREMENTS REGARDING THIS NOTICE** Community Partners of South Florida (CPSFL) is required to provide you with this Notice that governs our privacy practices. Community Partners of South Florida (CPSFL) may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any information we receive in the future. Any time you come in to CPSFL for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. **COMPLAINTS** If you believe your privacy rights have been violated, you may file a complaint with CPSFL or with the HHS Office of Civil Rights. You will not be penalized or retaliated against in any way for making a complaint.

Contact: Call CPSFL and ask to speak to the person/official responsible for privacy at **561-841-3500.**

If you have a complaint; if you have any questions about this notice; if you wish to request restrictions on uses and disclosure for health care, mental health services, or operations; you may obtain any of the forms mentioned to exercise your individual rights described above.

FINANCIAL PROCEDURES

The following is a statement of our Financial Policy that we ask you to read and acknowledge receipt of prior to beginning treatment.

PAYMENT

Your payment is due at the time of service. We accept checks, cash, money orders, or Mastercard/Visa. The adult accompanying a minor is responsible for payment.

MEDICAID PLANS

Medicaid contracts with Community Partners of South Florida (CPSFL) directly, so CPSFL is responsible for collecting co-payments at the time of service. If at any time your Medicaid is terminated, it is your responsibility to call our office to discuss the negotiation of fees. If no attempt is made to contact our office, you will be responsible for full fee for any services incurred after the termination date of Medicaid.

INSURANCE MANAGED CARE PLANS

Filing your insurance claim and requesting the initial authorization or pre-certification is a courtesy that we offer to you. If you are part of a plan for which we are a participating provider, all co-payments and deductibles are due at the time services are rendered. Please be advised that if at any time your insurance is terminated, it is your responsibility to call our office to discuss the negotiation of fees. If no attempt is made to contact our office, you will be responsible for full fee for any services incurred after the termination date of your insurance.

Community Partners of South Florida (CPSFL) is committed to providing the highest level of treatment to our patients. We charge what is usual and customary for this region. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Fees for services are assessed individually and discussed with you inadvance.

Thank you for reading our Financial Policy. Please contact CPSFL at (561) 841-3500 and ask to speak to a Billing Department Representative if you have any questions or concerns.

WRITTEN STATEMENT OF PURPOSE FOR COLLECTION OF SOCIAL SECURITY NUMBERS

By Florida Law, Community Partners of South Florida (CPSFL) is required to set forth, in writing, purposes for which it collects social security numbers. CPSFL is further required to provide individuals from whom it collects a social security number with a copy of the written statement setting forth those purposes.

Certain programs and services provided to members of the public by and through CPSFL are funded in whole or in part by the Department of Children and Families (DCF). An agency providing programs or services funded in whole or in part by DCF may share with DCF the social security number of an individual who is a recipient of any such programs or services. Therefore, CPSFL collects the social security numbers for the following purpose(s):

- To research, track and measure the impact of DCF-funded programs and services in an effort to maintain and improve such programs and services for the future (individual information will not be disclosed).
- To identify and match individuals and data within and among various systems and other agencies for research purposes.
- If applicable, to share information with the Florida Department of Health for purposes of Medicaid funding.

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FINANCIAL WORKSHEET & PAYMENT AGREEMENT

Client Name:_____ MR #: _____

Community Partners of South Florida is a not-for-profit corporation, supported in part by the State of Florida, private contributions and fees for service. The fees we receive are an essential part of our ability to continue providing services to the community.

Should your insurance plan require a co-pay for services rendered by Community Partners of South Florida (CPSFL) you will be responsible to pay those fees.

If you do not have one of the insurance plans we accept and are not covered by another payor or lose coverage during your treatment, you will be responsible for the copay determined by the attached sliding fee scale. The full fee for service is provided on the attached list. Your payment will be due at the time services are rendered.

This information will be utilized to determine sliding scale fee discount for clients that do not have Medicaid or other insurance coverage. This information is required for all applicants for service due to state and district data reporting requirements.

Number of Adults in the household:_____ Number of Children in the household: _____

Please list your household gross annual income: $_____or gross monthly income: $ _____

Please list the dollar amount of any assets listed in your name (include checking/savings accounts): $_____

Payment Agreement

I understand and agree that my payment for these services will be as outlined below. If circumstances change thereby affecting a family's income this agreement will be re-negotiated. I further agree to make payment at the time services are rendered or upon receipt of my monthly statement.

Based on the sliding fee scale, your co-payment/responsibility will be:

SERVICE	FEE
Biopsychosocial Assessment	
Brief Behavioral Health Status Exam	
Treatment Plan	
Treatment Plan Review	
Functional Assessment Rating Scale	
Individual/Family Therapy	
Targeted Case Management	
Therapeutic Behavioral On Site Service	
In-Depth Assessment	
0-5 Assessment	
Group Therapy	

Parent/Guardian_____ Date _____

Witness_____ Date_____