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***Harmony Healthcare***

# PATIENT REGISTRATION FORM

(Please complete in black ink only)

Client #_____

## *PATIENT INFORMATION*

| Last Name | First Name | Middle Initial | Home # | Work # | Cell # |
|---|---|---|---|---|---|
| Email address: | | | | Date of Birth | Age |
| Address | City | State ZIP | Sex (circle one) Male ☐ Female ☐ | | Social Security # |
| Marital Status | Employer/School | Address | | Occupation | Department |
| Emergency Contact (Other than someone that lives with you) | | | | Phone # | |

## *RESPONSIBLE PARTY/GUARDIAN (Individual signing this form)*

| Last Name | First Name | Middle Initial | Home # | Work # | Date of Birth |
|---|---|---|---|---|---|
| Address | City | State ZIP | Sex (circle one) Male ☐ Female ☐ | Marital Status | Social Security # |
| Employer | Employer's Address | | Occupation | Department | Relationship to Patient |

## *INSURED PARTY INFORMATION (Spouse or Parent if different from Responsible Party)*

| Last Name | First Name | Middle Initial | Home # | Work # |
|---|---|---|---|---|
| Employer | Employer's Address | | | Date of Birth |
| Relationship to Patient | Occupation | Department | | Social Security # |

## *PRIMARY INSURANCE INFORMATION*

| Insurance Company Name | Claims Mailing Address City State ZIP | | Phone # |
|---|---|---|---|
| ID# | Group Name and Number | Insured Party | Date of Birth |
| Effective Date | Deductible/Copay Information | Deductible Met? | Relationship to Patient |

## *SECONDARY INSURANCE INFORMATION*

| Insurance Company Name | Claims Mailing Address City State ZIP | | Phone # |
|---|---|---|---|
| ID # | Group Name and Number | Insured Party | Date of Birth |
| Effective Date | Deductible/Copay Information | Deductible Met? | Relationship to Patient |

I HEREBY GUARANTEE PAYMENT FOR THE ENTIRE BALANCE OF THE ABOVE-NAMED PATIENT. I AUTHORIZE TREATMENT OF THE ABOVE-NAMED PATIENT. I ASSIGN AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO HARMONY HEALTHCARE AND/OR ITS REPRESENTATIVES. I AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING CONFIDENTIAL MEDICAL RECORDS, REQUESTED BY INSURANCE COMPANIES, PAYORS, OR GOVERNMENT AGENCIES IN CONNECTION WITH THIS ASSIGNMENT. TO CANCEL AN APPOINTMENT, THE ABOVE-NAMED PATIENT MUST NOTIFY HARMONY HEALTHCARE AT LEAST 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT TIME, OR ELSE I WILL BE RESPONSIBLE FOR PAYING A $50.00 CANCELLATION FEE. IF THE ABOVE-NAMED PATIENT FAILS TO ATTEND AN APPOINTMENT, I WILL BE RESPONSIBLE FOR PAYING A $50.00 MISSED-APPOINTMENT FEE. I HAVE READ, UNDERSTAND, AND AGREE TO THE DESCRIBED DISCLOSURE, FINANCIAL POLICY, AND VARIOUS RELEASES AND GUARANTEES.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____



By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

**HARMONY HEALTHCARE**

# Consent for Treatment

Name of client: _____ Date of Birth: _____

I, _____, authorize Harmony HealthCare to provide mental health services for myself or for the above named individual. If the individual named above is a minor or an adult who has been adjudicated legally incompetent, I certify that I am the legal guardian of such person and have the legal right to approve of such services.

I understand that most information disclosed to Harmony HealthCare is protected by federal, state and local laws and regulations governing confidentiality. As such, I understand that much information cannot be disclosed to others without my written authorization, except under limited circumstances.

I understand that during the course of receiving services, Harmony HealthCare received, originates, maintains, discloses and uses individually identifiable protected health information (PHI), including but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatments, treatment plans and billing / health insurance information.

I understand that Harmony HealthCare and its employees and contractors, including physicians, therapists, social workers, interns, other health care professionals and administrative staff may use my PHI to perform the following tasks:

- Diagnose my medical, psychiatric, or psychological condition
- Plan my care and treatment
- Communicate with other health care professionals concerning my care
- Document the services I receive in order to obtain payment or reimbursement; and,
- Conduct routine health care operations related to Harmony HealthCare's business, including quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review ( the process of monitoring the effectiveness of health care personnel)

I understand that I do not have to consent to the use or disclosure of my PHI for treatment, payment and health care operations. However, I also understand that if I do not consent, Harmony HealthCare may refuse to provide me with treatment unless required by federal or state law.

I understand that I have the right to request restrictions on the use or disclosure of my PHI to carry out treatment, payment or health care operations, though Harmony HealthCare is not obligated to agree to the restrictions. To request such a restriction, I understand that I must place the request in writing and deliver it to Harmony HealthCare. Harmony HealthCare will review each request to determine if the restriction is agreeable and permitted by law.

# HARMONY HEALTHCARE

I understand that I may revoke this consent in writing by delivering to Harmony HealthCare a written notice of revocation. I understand that the revocation will not be effective to the extent that Harmony HealthCare has already taken action in reliance on my earlier effective consent.

I understand that there are legal expectations, in which my consent is not necessary to disclose PHI or similar information to others, including;

- In cases of past or present suspected child abuse or neglect, a report must be made to Child Protective Services
- In cases of abuse or neglect of 1) an individual older than age 60; or 2) a disabled individual; or 3) individuals adjudicated legally incompetent, a report must be made to local law enforcement agencies.
- For cases in which a client is in imminent risk of harming himself / herself or others, or when an individual with mental illness needs hospitalization, confidentiality may be suspended in order to protect the client or others, and to treat the mental illness.
- If a client appears to have been injured by a knife, firearm, or burn, such information must be reported to the applicable local law enforcement or local fire department agencies.
- Confidential information may also be disclosed when required by a valid court order or subpoena signed by a judge or magistrate, including but not limited to, cases in which a court orders a psychological evaluation.
- Harmony HealthCare may share confidential information about a deceased individual to the executor of the deceased's estate, or if a client's mental health information is necessary to determine the validity of a will.
- For cases in which a client's confidential information is part of a government investigation or hearing, including but not limited to, investigations conducted by the Nevada Board of Medical Examiners

I understand that Harmony HealthCare will provide the necessary staff for the purpose of treatment planning and management of the services I receive.

Please choos ***(please circle one)*** authorize Harmony HealthCare to leave phone messages, including voicemail and answering machine messages, about scheduling, canceling or confirming appointments.

Please choos ***(please circle one)*** authorization someone else to be able to call Harmony HealthCare to schedule, re-schedule, confirm or cancel appointments. I authorize _____ who is _____ (relationship to patient) to contact Harmony HealthCare to schedule, re-schedule, confirm or cancel appointments on my behalf.

I understand that this authorization is only allowed for scheduling needs. No information regarding treatment or medical care will be provided to the identified individual. Should I choose to allow additional information to be given; I will have to complete the Authorization for Disclosure form.

# HARMONY HEALTHCARE

I authorize Harmony HealthCare to open an account under my name for insurance benefits to be paid to Harmony HealthCare. I accept full financial responsibility for any payments not covered or paid for by insurance. Furthermore, I authorize Harmony HealthCare to release my PHI, including my medical records and any other information necessary to process any insurance claims or access employee benefits, including, but not limited to, my previous treatment history, mental health or substance abuse issues, and medical history.

I understand that if my account is in arrears, Harmony HealthCare has the sole discretion to refuse providing me with future appointments. I also understand that if my account is not paid in full within a period of time acceptable to Harmony Healthcare, a collection agency may be notified. I agree to pay all costs associated with the collection, as well as all attorneys' fees and court costs if a lawsuit is filed.

Please note that if Harmony HealthCare is not contracted with your secondary insurance, then all co-pays/ deductibles co-insurances are due at the time of service. Harmony HealthCare will provide a copy of the primary insurance explanation of benefits to you and /or guarantor.

I understand that if I do not show up for an appointment, or if I fail to cancel an appointment prior to 24 hours before my appointment time, Harmony HealthCare may charge me a missed-appointment fee of $50.00. I understand that the missed-appointment fee will not be covered by insurance, and so it is my responsibility to pay.

I have read and understand all of the provisions of this Consent for Treatment. I agree to abide by all of my obligations contained in this Consent for Treatment.

_____ _____

Client Signature Date

_____ _____

Spouse if Conjoint Treatment Date

_____ _____

Legal Guardian Signature (if applicable) Date

_____ _____

Witness Signature Date



By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

**HARMONY HEALTHCARE**

# Consent for Intern to Diagnose, Assess, and Treat Patient

Name of client: _____ Date of Birth: _____

Licensed Clinical Interns

Prior to obtaining licensure in the field of Social Work *(Licensed Clinical Social Work – LCSW), Marriage and Family Therapy (MFT), Licensed Drug and Alcohol Counselor (LADC), Certified Drug and Alcohol Counselor (CADC), or Certified Professional Counselor (CPC)* in the State of Nevada, individuals must complete an internship program in an approved clinical setting.

Harmony Healthcare is an approved clinical setting, which utilizes interns to diagnose, assess, and treat Harmony Healthcare's patients.

An on-site supervisor, approved by the State of Nevada, oversees the work of the interns.

The interns are required to maintain patient confidentiality, as required by both federal and state laws.

Consent

I have read the information presented above by Harmony Healthcare, and hereby consent to an Intern conducting my counseling sessions at Harmony Healthcare.

_____ _____
Client Signature (including minors) Date

_____ _____
Spouse Signature (if marital) Date

_____ _____
Legal Guardian Signature (if applicable) Date

_____ _____
Witness Signature Date

By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

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*MANDATORY*

Pt's Name: _____

DOB: _____

**Harmony Healthcare**

## Financial Responsibility Statement

All patient-pay portions are estimates based on the information provided to Harmony Healthcare by the patient and his or her insurance carrier. The patient/guarantor must understand that having an insurance benefit does not guarantee payment. The insurance carrier makes the final decision as to whether payment will be made after it receives and reviews the claim.

When a patient is treated at Harmony Healthcare, as a courtesy, Harmony Healthcare's staff contacts the patient's third-party payor to check insurance eligibility and pre-certification for insurance payment.

Also as a courtesy, Harmony Healthcare will bill the patient's insurance carrier for all services. The patient/guarantor is responsible for all outstanding balances should the insurance company fail to pay all or any part of the charges. The patient's Financial Counselor must be informed of all insurance coverage prior to the first visit. Any non-payment as a result of the patient's/guarantor's failure to provide insurance information prior to the first visit is also the patient's/guarantor's financial responsibility.

It is the patient's/guarantor's responsibility to ensure that all insurance premiums, dues, and COBRA payments are current throughout the patient's treatment at Harmony Healthcare. Any payment denied by the insurance carrier for services provided is the financial responsibility of the patient/guarantor.

The patient's insurance coverage is a contract between the patient and an insurance carrier – not between Harmony Healthcare and the insurance carrier. As such, the patient should be aware that insurance policies often change. As such, it is the patient's sole responsibility to know his or her coverage. Any costs incurred by the patient/guarantor due to a change in the patient's insurance policy is the sole responsibility of the patient/guarantor.

By signing below, the patient/guarantor acknowledges that they have read, understand and agree to all of the terms of this Financial Responsibility Statement.

_____ _____

Client Signature (including minors) Date

_____ _____

Legal Guardian Signature (if applicable) Date

_____ _____

Witness Signature Date



By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

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# DEMOGRAPHIC DATA FORM

**PATIENT NAME:**

**PATIENT DOB:** **CLIENT #:**

## DEMOGRAPHIC DATA

| *Gender* | *Ethnic Backgroud* | *Marital Status* | *Religion/Spiritual* |
|---|---|---|---|
| ☐ Male | ☐ African American | ☐ Married | ☐ Christian |
| ☐ Female | ☐ Asian/Pacific Island | ☐ Never Married | ☐ Jewish |
| ☐ Transgender | ☐ Caucasian, Euro-Am | ☐ Separated | ☐ Muslim |
| | ☐ Hispanic, Latino-Am | ☐ Divorced | ☐ Hindu |
| | ☐ Native Am | ☐ Widowed | ☐ Buddhist |
| | ☐ Other | ☐ Cohabitating | ☐ Other |
| | ☐ Data Not Available | ☐ Data Not Available | ☐ Data Not Available |

| *Sexual Orientation* | *Educational Level* | | *Legal issues* |
|---|---|---|---|
| ☐ Straight | ☐ Data Not Available | ☐ High School GED | ☐ Probation |
| ☐ Gay | ☐ K - 12 | ☐ Some College | ☐ Conditional release |
| ☐ Bi-sexual | ☐ Pre-Kindergarten | ☐ College Graduate | ☐ Incarceration |
| ☐ Transexual | ☐ Some High School | ☐ Graduate Degree | ☐ Current charges |
| ☐ Other | | | Describe:_____ |
| ☐ Data Not Available | | | _____ |
| | | | _____ |
| | If under 18, name of school:_____ | | ☐ Other:_____ |
| | School counselor?_____ | | _____ |
| | Is patient on an IEP? | | |

***Employment/Job Related Issues:*** Are you employed? _____

If No, how long have you been unemployed?_____ If Yes, what is your Occupation? _____

☐ Shift work ☐ Conflict at work ☐ Disabled

## ISSUES - Check all that apply

| | | |
|---|---|---|
| ☐ Alcohol | ☐ Post Traumatic Stress Disorder | ☐ Housing |
| ☐ Eating Disorder | ☐ Sexual Issues | ☐ Legal |
| ☐ Gambling | ☐ Stress/Burnout | ☐ School/Education |
| ☐ Illicit Drugs | ☐ Trauma | ☐ Chronic Pain |
| ☐ Prescription Drugs | ☐ Abuse/Neglect | ☐ Accident/Trauma |
| ☐ Anxiety | ☐ Dependent Care | ☐ Death of Co-Worker |
| ☐ Anger | ☐ Family/Child | ☐ Death - Family/Close Relationship |
| ☐ Behavioral/Conduct | ☐ Marital/Relationship | ☐ Fraud |
| ☐ Depression | ☐ Workplace - Peer | ☐ Serious illness/disability family |
| ☐ Grief/Loss | ☐ Workplace - Supervisor | |
| ☐ Learning-ADD/ADHD | ☐ Financial | |

1. Who referred you to Harmony Healthcare?_____

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*MANDATORY*

Pt's Name: _____

DOB: _____

**Harmony Healthcare**

# Bill of Rights

To Our Clients,

As recipients of services from Harmony Healthcare, you are entitled to the following rights:

- To receive services without regard to your race, color, religion, sex, age, marital status, national origin, veterans status, or disability.
- To be treated with respect, consideration, and dignity.
- To receive prompt, appropriate treatment and services, in accordance with the laws and standards governing the health care industry.
- To inquire and learn about the professional skills and qualifications of those who will provide your services.
- To participate in the planning and periodic review of your individual treatment plan.
- To be informed of all of your rights as our client.
- To refuse any form of treatment.
- To be informed about available treatment options and the effectiveness of any such options.
- To have your conversations and communications with your provider remain confidential, to the extent permitted by laws and professional standards.
- To receive a copy of your medical record, in accordance with our policies and procedures.
- To sign an informed consent if you desire to participate in any clinical or experimental research studies.
- To refuse to be filmed or taped.
- To receive information about the methods available to file a complaint or grievance regarding our provision of services to you, and know that you will not be retaliated against for filing any such grievance.
- To receive a copy of this Bill of Rights at any time.

By signing below, I acknowledge that Harmony Healthcare has provided me with the Bill of Rights written above, and that I have reviewed and understand all of the terms therein.

_____ _____

Client Signature (including minors) Date

_____ _____

Spouse (if Conjoint Treatment) Date

_____ _____

Legal Guardian Signature (if applicable) Date

_____ _____

Witness Signature Date

HH-014
Rev. 06/01/12

By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Pt's Name: _____
DOB: _____
MR#:_____

**HARMONY HEALTHCARE**
**NOTICE OF PRIVACY PRACTICES**

HARMONY HEALTHCARE will be referred to in this Notice of Privacy Practices ("Notice") as "Acadia". This Notice is given to you by an Acadia Facility to describe the ways in which Acadia may use and disclose your medical information (called "protected health information" or "PHI") and to notify you of your rights with respect to PHI in the possession of Acadia. Acadia protects the privacy of PHI, which also is protected from disclosure by state and federal law. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Acadia or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

Uses and Disclosures for Treatment, Payment and Health Care Operations

Acadia may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

FOR TREATMENT: Acadia may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities at another healthcare facility. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

FOR PAYMENT: Acadia may use and disclose PHI in order to collect payment for the health care services provided to you. For example, Acadia may need to give PHI to your health plan in order to be reimbursed for the services provided to you. Acadia may also disclose PHI to their business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. Acadia may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

FOR HEALTH CARE OPERATIONS: Acadia may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include hospital training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. Acadia may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes. These disclosures help make sure that Acadia is complying with all applicable laws, and are continuing to provide health care to patients at a high level of quality. Acadia may also disclose PHI to other health care facilities plans for certain of their operations, including their quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that those other facilities and plans have, or have had in the past, a relationship with the patient who is the subject of the information.

FOR SHARING PHI AMONG ACADIA AND PROFESSIONAL STAFF: Acadia works together with physicians and other care providers on their professional staff to provide medical services to you when you are a patient at an Acadia Facility. Acadia and members of their respective professional staff will share PHI with each other as needed to perform their treatment, payment and health care operations activities.

OTHER USES AND DISCLOSURES FOR WHICH AUTHORIZATION IS NOT REQUIRED: In addition to using or disclosing PHI for treatment, payment and health care operations, Acadia may use and disclose PHI without your written authorization under the following circumstances:

AS REQUIRED BY LAW AND LAW ENFORCEMENT: Acadia may use or disclose PHI when required by law, Acadia also may disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identify, description or location of a person who committed a crime, or for other law enforcement purposes.

FOR PUBLIC HEALTH ACTIVITIES AND PUBLIC HEALTH RISKS: Acadia may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

FOR HEALTH OVERSIGHT ACTIVITIES: Acadia may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: Acadia may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

ORGAN, EYE, AND TISSUE DONATION: Acadia may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

RESEARCH: Under certain circumstances, Acadia may use and disclose PHI for medical research purposes.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: Acadia may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: Acadia may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

SPECIALIZED GOVERNMENT FUNCTIONS: Acadia may use and disclose PHI of military personnel and veterans under certain circumstances, and may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

WORKERS' COMPENSATION: Acadia may disclose PHI to comply with workers' compensation or other similar laws that provide benefits for work-related injuries or illnesses.

HEALTH-RELATED BENEFITS AND SERVICES; LIMITED MARKETING ACTIVITES: Acadia may use and disclose PHI to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs.

**HARMONY HEALTHCARE**
**NOTICE OF PRIVACY PRACTICES**

Pt's Name: _____
DOB: _____
MR#:_____

DISCLOSURES TO YOU OR FOR HIPAA COMPLIANCE INVESTIGATIONS: Acadia may disclose your PHI to you or to your personal representative, and are required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. Acadia must disclose your PHI to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Uses and Disclosures to Which You May Object:
You may object to the following uses and disclosures of PHI that Acadia may make:

PATIENT DIRECTORIES: Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts.

Other Uses and Disclosures of PHI for Which Authorization Is Required:
Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which you have the limited right to revoke in writing.

REGULATORY REQUIREMENTS: Acadia is required by law to maintain the privacy of your PHI, to provide individuals with notice of their legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. Acadia reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before Acadia makes an important change to its privacy policies, they will promptly revise this Notice and post a new Notice in registration and admitting areas. You have the following rights regarding your PHI:

You may request the Acadia restrict the use and disclosure of your PHI. Acadia is not required to agree to any restrictions you request, but if the entity does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from Acadia be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be in writing and sent to the Privacy Officer. Acadia will accommodate your reasonable requests without requiring you to provide a reason.

Generally, you have the right to inspect and copy your PHI in the possession of Acadia if you make a request in writing to the applicable Acadia Hospital's Medical Records Department. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), Acadia will inform you of the extent to which your request has or has not been granted. In some cases, Acadia may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, Acadia may impose a reasonable fee to cover copying, postage, and related costs. If Acadia denies access to your PHI, it will explain the basis for denial and your opportunity to have the denial reviewed by a licensed health care professional (not involved in the initial denial decision) designated as a reviewing official. If Acadia does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

If you believe that your PHI maintained by Acadia contains an error or needs to be updated, you have the right to request that the entity correct or supplement your PHI. Your request must be made in writing to the local Medical Records Department and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), Acadia will inform you of the extent to which your request has or has not been granted. Acadia generally can deny your request if your request relates to PHI: (i) not created by Acadia; (ii) that is not part of the records Acadia maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, Acadia will give you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) submit a request that any future disclosures of the relevant PHI be made with a copy of your request and Acadia's denial attached, if you do not file a statement of disagreement; and (iii) complain about the denial.

You generally have the right to request and receive a list of disclosures of your PHI Acadia has made during the six (6) years prior to your request (but not before April 14, 2003). The list will not include disclosures (i) for which you have provided a written authorization; (ii) for treatment, payment, and health care operations; (iii) made to you; (iv) for an Acadia patient directory or to persons involved in your health care; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (vii) of a limited data set. You should submit any such request to the Privacy Officer, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), Acadia will respond to you regarding the status of your request. The entity will provide the list to you at no charge, but if you make more than one request in a year you will be charged $25.00 for each additional request.

You have the right to receive a paper copy of this notice upon request even if you have agreed to receive this notice electronically. You can view a copy of this notice on Acadia's website, www.acadiahealthcare.com. To obtain a paper copy of this notice, please contact the Privacy Officer.

You may complain to Acadia if you believe your privacy rights with respect to your PHI have been violated by contacting Acadia's Privacy Officer and submitting a written complaint. Acadia will not penalize you or retaliate against you for filing a complaint regarding their privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.E., Washington, DC 20201.

If you have any questions about this notice, please contact Acadia Healthcare's Compliance Hotline toll-free 866-500-0333, or email to corporatecompliance@acadiahealthcare.com or write to 830 Crescent Centre Drive, Suite 610, Franklin, TN 37067

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of "HARMONY HEALTHCARE's *Notice of Privacy Practices.*

_____ _____
Signature of Client Date

By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

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**Harmony Healthcare**

Client #: _____

Client Questionnaire

Name of client: _____Date: _____

Name of person completing form: _____

Relationship to client: _____

1. Describe the recent events or problems you have been having that led you to seek mental health services? (Include when these problems began and how frequently they occur).

2. Describe how the problems above affect your daily functioning (i.e. do they cause problems at school, with your job, with relationships, physical problems, etc.?)

3. Describe any significant events in the past or current stressful experiences that might be affecting you today

**HARMONY HEALTHCARE**
**(702) 251-8000**

## Medical Advisory Form

***Note: First page to be completed by client***

The patient named below is / was (please circle one) being treated at Harmony Healthcare. Harmony Healthcare is providing you with this information for the coordination of the patient's medical treatment. This information is protected by federal, state, and local laws governing patient confidentiality.

**PERSONAL INFORMATION**:

Name of Patient: _____ DOB: _____ Client #: _____

Name of Primary Care Physician ("PCP"): _____

Address of PCP: _____

PCP Phone #: _____ PCP Fax #: _____

Harmony Provider: _____

Frequency of appointments (weekly, monthly, and other): _____

**PATIENT CONSENT:**

I, _____ , Please ch **(please circle one)** authorize Harmony Healthcare to provide my confidential information to my Primary Care Physician named above, in order to assist in my treatment.

This information Please choc **(please circle one)** be transmitted via fax machine to the fax number listed above.

If consent is not provided, please state the reason(s) for the refusal:

_____

_____
Client Signature (including minors) Date

_____
Legal Guardian Signature (if applicable) Date

_____
Witness Signature Date

***See page 2 for additional information — page 2 to be updated at initiation and change of all medications***

By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

**HARMONY HEALTHCARE**
**PATIENT MEDICATION CONTRACT**

Pt's Name: _____
MR#:_____
Treating Provider: _____

# Medication Contract

I, _____, have been educated and agree to the following rules and conditions regarding prescriptions and/or refills of medications. Harmony Healthcare will provide you with the medication prescriptions that are needed if you agree to the following guidelines:

1. I am responsible for my medications. If my medication is lost, misplaced, or stolen I understand that they will not be automatically replaced. They may be replaced only at the discretion of my physician or other practitioner.
2. I will strictly adhere to the prescription dosage as recommended by my physician or practitioner.
3. I will not make dosage changes without my practitioner's knowledge and/or consent.
4. I will not give my medications to other people. I will safeguard my prescriptions for personal use only.
5. If my medications are a controlled substance (i.e. Xanax, Adderall, etc.) I realize I must make another medication appointment to have them refilled. I acknowledge that my prescriptions for these medications will not be called into a pharmacy should I lose them, run out, etc.
6. Harmony Healthcare is not a pharmacy. Samples will not be provided. If you cannot afford a medication that is prescribed to you, your prescribing practitioner will provide you with medication options that you can afford. We will assist you with applications to Patient Assistance Programs through pharmaceutical companies if you are eligible.
7. **Harmony Healthcare DOES NOT accept refill requests from pharmacies that are faxed to us. I fully acknowledge that I must schedule and attend a scheduled appointment and have my medication prescriptions filled with my provider. I understand that if I need a refill, I will call my provider with at least 48 hours prior to running out to request a refill. I will not rely on a pharmacy to fax Harmony Healthcare**
8. I understand that I cannot call and ask to be put into "Triage" if I have a medication problem (i.e. lost, stolen, run out of medication, etc.).
9. I understand that I must schedule my medication appointments and attend them in order to receive medications. I understand that it is my responsibility to check my supply of medications and schedule the appointment in a timely manner as to avoid running out of medications.
10. I understand that failure to comply with any of these conditions listed above could result in termination of medication services from Harmony Healthcare.

_____ _____
Patient Signature Date

_____ _____
Witnessed By Date

_____ _____
Physician or Provider Date



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