



**SAI RESIDENTIAL TREATMENT CENTER
APPLICATION FOR TREATMENT**

APPLICANT INFORMATION

Today's Date: _____

Name: _____

DOB: _____ Age _____

Race:
 White Black or African American Asian American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Other _____

Ethnicity:
 Hispanic Non Hispanic

Phone #: _____ Is this a: Cell Phone Home Phone

Email: _____

Current physical address:

Current mailing address (if different from physical):

Marital status: Single Married Separated Divorced Widowed Partnership

Do you have Health Insurance? Yes No

If so, please list:

1. **Primary** Insurance Provider Name

Name of Insured _____

Member ID# _____

2. **Secondary** Insurance Provider
Name _____

Name of Insured _____

Member ID# _____

Who referred you to us: _____

MEDICAL



Do you have a Primary Care Physician? Yes No
If so, please list name, address and phone number of your PCP

So you take any prescription medications: Yes No If yes, Please list:

_____ _____
 _____ _____
 _____ _____
 _____ _____

Do you have any medical conditions or allergies: Yes No
If yes, please explain:

RECOVERY AND SUBSTANCE USE (Only complete if applicable to you)

Do you think you have a problem with alcohol: Yes No
If yes, please explain

Do you think you have a problem with drugs: Yes No
If yes, please explain

Primary addiction: _____ Date of last use: _____

List drugs/alcohol you used addictively:

1st _____ Route: _____
Date of last use: _____ Age of 1st use: _____
2nd: _____ Route: _____
Date of last use: _____ Age of 1st use: _____
3rd: _____ Route: _____
Date of last use: _____ Age of 1st use: _____

Do you have any other recognized addictions or disorders (i.e. Eating disorder, gambling, sex, eating): YesNo
If so, please explain:



How long have you been clean/sober:

What is the longest you have gone substance free: _____

How many previous recovery attempts/relapses have you had:

Are you on any maintenance programs, and if so, which:

MENTAL HEALTH

Have you ever received a mental health diagnosis: Yes No

If yes, please list diagnoses you have received

Name of Doctor, Therapist or other who diagnosed you:

Are you currently in counseling Yes No

If so, where do you receive counseling services:

Name of therapist _____

Do you currently receive psychiatric services: Yes No

If so, where do you receive services:

Name of Psychiatrist: _____

Are you currently prescribed any psychiatric medications: Yes No

If so, list medications, dosages and if you are currently taking as prescribed:

LEGAL

Have you been arrested in the past 30 days: Yes No

If yes, explain:



Are you currently on probation or parole: Yes No
If yes:

Probation Officer: _____ Phone: _____

Are you Court Order for Counseling? Yes No

Are you experiencing legal problems (i.e. Court dates, warrants, active restraining orders):

Please describe:

OTHER INFORMATION

Please list hobbies and special interests:

What would you say your best characteristics are:

What are your top 3 goals at this time, related to Mental Health and/or Substance Use

- 1. _____
- 2. _____
- 3. _____

On a scale of 1-10, how motivated are you to work on achieving these goals?

1 2 3 4 5 6 7 8 9 10

Please list anything else you feel is relevant to this application:

Patient/Client Name (Printed) _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



**AUTHORIZATION TO RELEASE INFORMATION
TO BE COMPLETED BY SAI MENTAL HEALTH STAFF MEMBER ONLY**

Name of Client: _____

I hereby request and authorize:

Sai Residential Treatment Center, 2480 Sandestin Drive, Reno, NV 89523

To disclose to or obtain from (Name of person or business you give permission to release information to/Always include Emergency Contact if such a person is designated by client):

The following types of information from my records (and any specific portion thereof):

- Medical history/Physicals
- Alcohol and drug abuse treatment record
- Laboratory reports
- Psychological evaluations
- Other Contact in emergencies

For the purpose of (Specific...ex: Coordination of Care):

I hereby authorize my information to be obtained from the agency listed above. The information will be maintained and is strictly confidential and cannot be released by the recipient without my written consent.

I understand that this authorization will remain in effect for:

- Ninety (90) days unless otherwise an earlier time period of _____
- One (1) year
- 60 days after discharge from the program (Always checked if releasing information)

I understand that unless otherwise limited by state or Federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Signature of Client: _____ Date: _____

Signature of Witness (Staff Member): _____ Date: _____

Sai Mental Health Designated Representative _____ Date: _____

To be used only if Client withdraws consent:

Client signature: _____ Date: _____

The information which is being disclosed is from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibit disclosures without the specific consent of the person to whom it contains. A general authorization is NOT sufficient for such release. The Federal rules restrict any use of this information from a criminal investigation or to prosecute any alcohol or drug abuse patients.



SAI RESIDENTIAL TREATMENT CENTER

CLIENT COMPLAINT PROCESS

1. If you have a minor complaint or grievance, please report it to the staff person concerned.
 - a. If the complaint is not able to be resolved to the applicable person's satisfaction, then please inform the Office Manager.
 - b. If the complaint is not able to be resolved to your satisfaction, you'll be directed to the Chief Executive Officer.
2. Complaints shall be handled within three business days of receipt. Complaints shall be resolved and resolution shall be reviewed with applicable person.
3. All complaints and grievances are to be handled as priority items, none of which should require more than three business days for a response.
4. Complainants shall be given a fair opportunity to be heard and to have their questions answered.
5. If a grievance is filed against a member of the staff, a review of the case shall be conducted by the Operations Director for the express purpose of grievance adjudication.
6. There shall be no barriers to treatment or services or events of retaliation by staff members against any client or caregiver who files a complaint.
7. Penalties may not be initiated prior to final resolution, with the exception that penalties may be initiated against anyone who has committed or threatened to commit physical violence.
8. If the complainant is dissatisfied with the above responses, then the complaint is turned over to the COO or designee. The COO or designee shall handle the complaint within two business days. The complaint shall be resolved and resolution shall be reviewed with client.
9. All written complaints shall be reviewed and filed with the COO. In addition, a written record of the complaint will be forwarded to the Compliance Officer.
10. An Annual Review shall be conducted with the COO, Compliance Officer, and Site Managers.

If you have any complaint regarding Sai Residential Treatment Center or any staff members within our agency, please request a Grievance Form from our Front Desk Receptionist.

I have read and understand the client complaint process

Client Name (Print) _____

Client Signature _____ Date _____

Legal Guardian Signature _____ Date _____



**SAI RESIDENTIAL TREATMENT CENTER
PATIENT CONFIDENTIALITY AGREEMENT**

Confidentiality:

The counseling relationship is built on trust between counselor and patient, therefore anything that is shared in session will remain confidential.

There are some limits to this, which are:

1. If we believe, or you report, that you are a direct and imminent danger to yourself or others
2. If you disclose neglect, physical, verbal or sexual abuse is occurring
3. If you are court ordered to therapy or if any court appointed agency requests your records

Confidentiality is ensured during all face-to-face communication, but we cannot ensure that electronic communication by telephone or internet will be 100% confidential. We make every effort to ensure that your Protected Health Information is protected and confidential at all times. Please be aware that if you choose to communicate with any staff at Sai Residential Treatment Center through email, texting or social media or any Telehealth platform, we cannot guarantee confidentiality.

Patient records including assessment, treatment planning and progress notes are the property of Sai Residential Treatment Center and can be supplied to you if requested.

Confidentiality Agreement

I _____ consent to receiving counseling from Sai Residential Treatment Center. It has been explained to me that all personal information that I chose to disclose is confidential, will not be shared with any other person unless consented to, and will be kept in a secure location.

- My personal details will not be given to any other person or agency

Patient/Guardian Name: _____

Signature _____

Date _____

Sai Staff Signature _____

Date _____



CONSENT TO TREATMENT

Consent for Treatment

Sai Residential Treatment Center

I, _____, have chosen to receive Residential Behavioral Health treatment for:

- Mental Health Counseling
- Substance Abuse Treatment
- Treatment for both Mental Health and Substance Abuse

for myself and/or my child from Sai Residential Treatment Center. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

What do the services include:

Mental Health Counseling (Individual, Family, Group): A mental health counselor provides support to those experiencing mental or emotional distress. They may use a variety of therapeutic techniques to help a person manage anxiety, depression, and other mental health conditions. Mental health counselors can offer advice, support, and a safe space to talk about the problems a person is struggling with.

For example, they can help you:

- understand your feelings
- identify issues that affect your mental health
- discover ways to overcome them
- learn new skills and coping strategies
- set goals for personal growth
- learn more about mental health conditions

Substance Abuse Counseling (Individual, Family, Group):

Substance abuse counselors help people experiencing substance use and drug addiction problems. They provide treatment and support for people trying to overcome substance use disorders or addictions. Behavioral therapies help people in drug addiction treatment modify their attitudes and behaviors related to drug use. As a result, patients are able to handle stressful situations and various triggers that might cause another relapse. Behavioral therapies can also enhance the effectiveness of medications and help people remain in treatment longer.

Benefits of Mental Health Treatment

1. Improved communication and interpersonal skills
2. Improved self-acceptance and self-esteem
3. Capability to change self-defeating behaviors and habits
4. More suitable expression and management of emotions
5. Relief from depression, anxiety, or other mental health conditions
6. Greater confidence and decision-making skills
7. Ability to manage stress more effectively
8. Improved abilities for problem-solving and conflict resolution



Benefits of Substance Abuse Treatment

- 1. Counseling can identify situations contributing to substance use.
- 2. Counseling can provide direct support for addiction.
- 3. Counseling can provide peer support for addiction.
- 4. Counseling can offer new behavior strategies for recovery.
- 5. Counseling can reduce the risk of relapse.

Risks of Mental Health Counseling and/or Substance Abuse Treatment:

- 1. Triggers for past trauma, emotions, use, etc
- 2. Periods of emotional disturbance as you work through the issues which brought you to treatment

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Reason for seeking treatment

In your own words (using quotations), please explain why you feel that Outpatient Counseling with Sai Residential Treatment Center will be helpful for you:

“ _____

 _____”

I have read, discussed and understand the above statements and consent to treatment with Sai Residential Treatment Center

Client Name (Print) _____ Date _____

Signature _____

Parent/Guardian signature _____ Date _____



**ONLINE SCHOOL
FINANCIAL ASSISTANCE REQUEST FORM**

Name of child: _____

Name(s) of Parent/Guardian(s): _____

Home address: _____

Phone number: _____

Is it okay for Sai RTC to leave a message on this phone? YES NO

Date of request: _____

I, _____, am requesting financial assistance for my child to participate in Online Education with Advantages Digital Learning Systems while under the care of Sai Residential Treatment Center.

The reason for this request:

I am requesting:

- Full price of \$386.00 per month
- 50% of total monthly cost: \$193.00 per month
- 25% of total monthly cost: \$96.50 per month
- 0% of total monthly cost: \$0.00 per month and agree to be financially responsible for my child's full monthly tuition

Parent/Guardian Signature

Date

CEO Signature

Date



HIPAA Information and Patient Privacy Consent

Patient's Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- All other disclosures by the practice will require specific authorization by you unless required by law
- The practice has a Notice of Privacy Practices and that the patient can review this Notice and receive a copy upon request.
- The practice reserves the right to change the Notice of Privacy Practices Policies. The new Policy will be posted in the Lobby and on the Website.
- The patient has the right to restrict the uses of their information used for treatment, payment or operations, but the Practice does not have to agree to those restrictions.

Parent/Guardian Signature _____ Date _____

Practice Staff Member Signature _____ Date _____



**ONLINE SCHOOL
PERMISSION FORM**

Parents/Guardians,

At Sai Residential Treatment Center, we understand the importance of your child staying up-to-date with their education and we want to fully support your family in this area.

Sai RTC has partnered with Advantages Digital Learning Systems, which is a fully accredited online schooling program. We will be providing online education for each child in the RTC Monday through Friday to ensure they are maintaining their educational goals.

While your child is under the care of Sai RTC, parents/guardians have the option to have their child participate in online instruction. Sai staff will oversee your child's daily school schedule with the assistance of distance learning professionals from Advantages DLS.

Financial information:

1. Online schooling program for Sai RTC has a cost of \$386.00 per month. This includes:
 - a. At least 15 direct school hours per week
 - b. Online portal that may be accessed by parent/guardians
 - c. Fully accredited which means all credits earned during this program will be fully transferrable to any public or private school once your child discharges from Sai.
2. If your child is behind in school or is working at a different grade level than his/her age, they will have the opportunity to take a placement exam and their online program will be tailored from the results.
 - a. This placement test is a one-time fee of \$50.00

If you are in need of financial assistance for this program, please complete the attached Financial Assistance form to be reviewed by Sai Leadership.

Advantages DLS has agreed to partner with Sai RTC and provide discounted monthly rates. If you should decide to have your child continue their education with Advantages DLS after your child discharges from Sai RTC, please contact them directly for pricing information.

If you would like your child to participate in this program, please complete the information below.

By submitting this form with my signature, I am consenting for my student to participate in virtual group instruction through live online work sessions. I, _____ hereby agree to allow Sai Residential Treatment Center to use an online platform for Individual and/or group sessions with my child,

_____.

You may withdraw your consent to use this platform at any time. A request to withdraw your consent should be submitted in writing to the Chief Executive Officer and the Office Manager at jbussey@saimentalhealth.org and lorir@saimentalhealth.org

Signature of Parent, Guardian, or Eligible Student (18 years or older)

Date



SAI RESIDENTIAL TREATMENT CENTER
PATIENT'S RIGHTS AND RESPONSIBILITIES

Sai Residential Treatment Center Client Rights are as follows:

- 1) To be treated with dignity and respect
- 2) To participate actively in your recovery
- 3) To be given information regarding informed consent prior to the start of your stay.
- 4) Be seen by a private physician with the understanding that all costs will be the responsibility of the client.
- 5) Have all information pertaining to stay held in confidence.
- 6) Receive information regarding costs.
- 7) Be fully informed at the time of admission of the rights and responsibilities set forth herein and of all the rules and guidelines governing client conduct.
- 8) Initiate a complaint or grievance procedure and understand that you may begin the process by filling out a grievance slip or contacting Sai Residential Treatment Center owner, staff member or volunteer.
- 9) Request referral resources in the event of your dismissal from Sai Residential Treatment Center.
- 10) Not to be required to perform services for Sai Residential Treatment Center.

If you will be receiving treatment for abuse of/or dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

1. If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.
2. You have the right to be provided treatment appropriate to your needs.
3. If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.
4. You have the right to be informed of all program services, which may be of benefit to your treatment.
5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
6. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.
7. You have the right to be informed of our diagnosis, treatment plan and prognosis.
8. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.



9. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.
10. You have the right to be informed of the program’s rules for your conduct at the facility.
11. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
12. You have the right to receive respectful and considerate care.
13. You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.
14. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.
15. You have the right to safe, healthful and comfortable accommodations.
16. You have the right to confidential treatment. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that you are a patient.
17. Waiver of any civil or other right protected by law cannot be required as a condition of program services.
18. You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.
19. You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.
20. You have the right to grieve actions and decisions of facility staff, which you believe, are inappropriate, including but not limited to acts and decisions, which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retaliation or other adverse consequences as the product of filing a grievance.
21. You have the right to file a complaint with the State of Nevada if the facility’s grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency, 4126 Technology Way, 2nd Floor Carson City, Nevada 89706. Att: Treatment Supervisor Phone: 1-775-684-4190
22. You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

Patient acknowledgement:

I have read, understand, and have been provided a copy of the above Patient’s Rights.

Patient Signature

Date

Parent/Guardian Signature

Date



Privacy Policy

Commitment to Privacy

The appropriate collection, use and disclosure of patients' personal health information is fundamental to our day-to-day operations and to patient care. Protecting the privacy and the confidentiality of patient personal information is important to the physicians and staff at Strong Minds Residential Treatment Center. We strive to provide our patients with excellent medical care and service. Every member of Strong Minds Residential Treatment Center must abide by our commitment to privacy in the handling of personal information.

Applicability of This Privacy Policy

Our Privacy Policy attests to our commitment to privacy and demonstrates the ways we ensure that patient privacy is protected. Our Privacy Policy applies to the personal health information of all our patients that is in our possession and control.

What is Personal Health Information?

Personal health information means identifying information about an individual relating to their physical or mental health (including medical history), the providing of health care to the individual, payments or eligibility for health care, organ and tissue donation and health number.

The 10 Principles of Privacy Our Privacy Policy - Reflects our compliance with fair information practices, applicable laws and standards of practice.

1. **Accountability** We take our commitment to securing patient privacy very seriously. Each physician and employee associated with the Practice is responsible for the personal information under his/her control. Our employees are informed about the importance of privacy and receive information periodically to update them about our Privacy Policy and related issues.

2. **Identifying Purposes: Why We Collect Information** We ask you for information to establish a relationship and serve your medical needs. We obtain most of our information about you directly from you, or from other health practitioners whom you have seen and authorized to disclose to us. You are entitled to know how we use your information and this is described in the Privacy Statement posted at Strong Minds Residential Treatment Center. We will limit the information we collect to what we need for those purposes, and we will use it only for those purposes. We will obtain your consent if we wish to use your information for any other purpose.

3. **Consent** You have the right to determine how your personal health information is used and disclosed. For most health care purposes, your consent is implied as a result of your consent to treatment, however, in all circumstances express consent must be written. Your written Consent will be forwarded to the Privacy Officer who will document the request in patient's medical records and notify appropriate Health care providers and their supporting staff. Patients who have withdrawn consent to disclose PHI must sign and date the Consent to Withdrawal Form. It is understood that the consent directive applies only to the PHI which the patient has already provided, and not to PHI which the patient might provide in the future: PHIPA permits certain collections, uses, and disclosures of the PHI, despite the consent directive; healthcare providers may override the consent directive in certain circumstances, such as emergencies; and the consent directive may result in delays in receiving health



care, reduced quality of care due to healthcare provider's lacking complete information about the patient, and healthcare provider's refusal to offer non-emergency care. Your written Consent to Withdrawal Form will be forwarded to the Privacy Officer who will document the request in patient's medical records and notify appropriate Health care providers and their supporting staff.

4. Limiting Collection We collect information by fair and lawful means and collect only that information which may be necessary for purposes related to the provision of your medical care.

5. Limiting Use, Disclosure and Retention The information we request from you is used for the purposes defined. We will seek your consent before using the information for purposes beyond the scope of the posted Privacy Statement. Under no circumstances do we sell patient lists or other personal information to third parties. There are some types of disclosure of your personal health information that may occur as part of this Practice fulfilling its routine obligations and/or practice management. This includes consultants and suppliers to the Practice, on the understanding that they abide by our Privacy Policy, and only to the extent necessary to allow them to provide business services or support to this Practice. We will retain your information only for the time it is required for the purposes we describe and once your personal information is no longer required, it will be destroyed. However, due to our on-going exposure to potential claims, some information is kept for a longer period. Patients may be required to sign and date a Consent to Disclose PHI Form and pay a fee based on current OMA rates prior to release of information.

6. Accuracy We endeavour to ensure that all decisions involving your personal information are based upon accurate and timely information. While we will do our best to base our decisions on accurate information, we rely on you to disclose all material information and to inform us of any relevant changes.

7. Safeguards: Protecting Your Information We protect your information with appropriate safeguards and security measures. The Practice maintains personal information in a combination of paper and electronic files. Recent paper records concerning individuals' personal information are stored in files kept onsite at our office. Older records may be stored securely offsite. Access to personal information will be authorized only for the physicians and employees associated with the Practice, and other agents who require access in the performance of their duties, and to those otherwise authorized by law. We provide information to health care providers acting on your behalf, on the understanding that they are also bound by law and ethics to safeguard your privacy. Other organizations and agents must agree to abide by our Privacy Policy and may be asked to sign contracts to that effect. We will give them only the information necessary to perform the services for which they are engaged, and will require that they not store, use or disclose the information for purposes other than to carry out those services. Our computer systems are password-secured and constructed in such a way that only authorized individuals can access secure systems and databases. If you send us an e-mail message that includes personal information, such as your name included in the "address", we will use that information to respond to your inquiry. Please remember that e-mail is not necessarily secure against interception. If your communication is very sensitive, you should not send it electronically unless the e-mail is encrypted or your browser indicates that the access is secure.

8. Openness: Keeping You Informed The Practice has prepared this plain-language Privacy Policy to keep you informed. You may view a copy by visiting our website at www.family-medicine.ca. If you



have any additional questions or concerns about privacy, we invite you to contact us by phone and we will address your concerns to the best of our ability.

9. Access and Correction With limited exceptions, we will give you access to the information we retain about you within a reasonable time, upon presentation of a written request and satisfactory identification. We may charge you a fee for this service and if so, we will give you notice in advance of processing your request. If you find errors of fact in your personal health information, please notify us as soon as possible and we will make the appropriate corrections. We are not required to correct information relating to clinical observations or opinions made in good faith. You have a right to append a short statement of disagreement to your record if we refuse to make a requested change. If we deny your request for access to your personal information, we will advise you in writing of the reason for the refusal and you may then challenge our decision.

10. Challenging Compliance We encourage you to contact us with any questions or concerns you might have about your privacy or our Privacy Policy. We will investigate and respond to your concerns about any aspect of our handling of your information. In most cases, an issue is resolved simply by telling us about it and discussing it. You can reach us at: Jeanette Bussey, Chief Executive Officer, Strong Minds Residential Treatment Center 775-800-1136



Telehealth Health Informed Consent

I, _____, hereby consent to participate in Telehealth health with, _____, as part of my psychotherapy. I understand that Telehealth health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to Telehealth health:

- 1)I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2)I understand that there are risks, benefits, and consequences associated with Telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3)I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4)I understand that the privacy laws that protect the confidentiality of my protected health information(PHI) also apply to Telehealth health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5)I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telehealth health services are not appropriate and a higher level of care is required.
- 6)I understand that during a Telehealth health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to discuss since we may reconnect within ten minutes, please call me at _____ have to re-schedule.
- 7)I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person’s name, address, phone:

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian _____ Date _____

SAI RTC

Parent/Guardian "Right to Bill" Acknowledgment and Financial Responsibility Form

Location: Reno, Nevada

| | |
|-------------------------|--|
| Client Name: | |
| Date of Birth: | |
| Parent/Guardian Name: | |
| Relationship to Client: | |

Purpose of This Form

This document explains your rights and responsibilities related to billing for services provided by SAI RTC. Please review carefully before signing.

1. Authorization to Bill

I authorize SAI RTC to bill my insurance company and/or myself directly for all professional services rendered to the client listed above. I understand that my insurance company is to pay SAI RTC directly for all covered services provided. If my insurance company issues payment to me instead of SAI RTC, I agree to notify SAI RTC immediately and forward or remit those funds within seven (7) days of receiving the payment.

2. Financial Responsibility

I acknowledge that I am financially responsible for any portion of fees not covered by my insurance, including copays, coinsurance, deductibles, or denied claims. I agree to inform SAI RTC promptly of any changes in insurance coverage. I understand that unpaid balances may result in temporary suspension of services until payment arrangements are made.

3. Communication About Billing

SAI RTC may contact me via phone, email, or mail regarding billing questions, insurance matters, or account balances.

Preferred Contact Method

Phone Email Mail

4. Assignment of Benefits

I hereby assign all insurance benefits directly to SAI RTC for services rendered. I authorize SAI RTC to release any necessary information to my insurance company for the purpose of processing claims or verifying benefits.

5. Acknowledgment of Receipt

By signing below, I acknowledge that I have read and understood this document. I understand my rights and obligations regarding billing and payment for services provided to my child, and that insurance payments are to be made directly to SAI RTC.

Parent/Guardian Signature: _____

Date: _____

SAI RTC Representative: _____

Date: _____