New Client Orientation Packet

Therapeutic Partners, LLC.
60 Louis Prima Drive, Suite A
Covington, LA 70433

Phone: (985) 327-5427
Fax: (985) 327-8800

Office Hours:
Monday - Thursday 9am to 4:30pm
Friday -9am to 3:00pm

HIPAA

Notice of Privacy Practices

60 Louis Prima Dr. Ste. A
Covington, LA. 70433
Office: (985)327-5427
Fax: (866)300-8753
Email: admin@therapeuticpartners.net

Introduction

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This facility is committed to treating and using protected health information about you responsibly. This Notice describe the personal information we collect, and how and when we use or disclose that information. It also describes your right as they relate to your personal health information.

This Notice of Privacy Practices is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Protected Health Information

Each time you visit this facility, a record of your visit is made. This record is often referred to as your “medical record” or “health record”. Typically, this record contains information such as:

- Your medical and/or psychiatric history;
- You diagnosis(es);
- Progress notes(treatment details);
- A plan for current and future care;
- Treatment goals;
- Records from others who treated you;
- Information about medication you take;
- Legal matters; and
- Billing and insurance information

The protected health information contained in your medical record serves as a:

- Basic for planning your care and treatment.
- Means of communication among the health professional who contribute to your care.
- Legal document describing your treatment.
- Means for you or third party to verify that services billed were actually provided.
- A tool to educate health professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A data source for planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your medical record and how your health information is used helps to: ensure it's accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure of your health information to others.

Your Health Information Rights

Although your medical record is the physical property of this facility, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request;
- Inspect and copy your medical record
- Amend your health record
- Obtain an accounting of disclosure of the health information in your medical record
- Request a restriction on certain uses and disclosures of your health information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This Facility's Responsibilities

In accordance with State and Federal laws, it is the responsibility of this facility to:

- Maintain the privacy of your health information;
- Provide you with this notice describing our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate protected health information by alternative means or at alternative locations;
- Not use or disclose your protected health information without your authorization, except as described in this notice; and
- Discontinue to use or disclose your protected health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Right to Revise Privacy Practices

As permitted by law, this facility reserves the right to change or amend our privacy practices and to make the new provisions effective for all protected health information we maintain. Such changes may be required by changes in State or Federal HIPPA laws and regulations concerning protected health information. Upon request, a copy of the most recently revised Notice of Privacy Practices will be provided to you.

Use and Disclosure of Your PHI

When your PHI is viewed within this facility, it is called "use". When it is sent to or shared with others outside this facility, it is called "disclosure". In all circumstances, this facility will only disclose the *minimum necessary* PHI required for the needed purpose.

PHI Use and Disclosure With Your Consent

After you read this Notice, you will be asked to allow this facility to use and share your PHI. In most cases, your PHI will be used at this facility or shared with others to provide treatment to you, arrange for payment for services, or other business functions called health care operations. These three things are called TPO, and the Consent form allows us to use and disclose your PHI for TPO purposes.

In order for your treatment to begin, you must consent to allow this facility to collect, use, and share information about you. If you do not consent we cannot treat you. Several staff members at our facility may collect information about you and place it in your health record here.

For Treatment

We use your medical information to provide you with psychiatric treatment or services including individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the effects of our services. We may also share or disclose your PHI to others who provide treatment to you including your personal physician and other treatment team providers, if applicable.

In the event you are in need of special testing or treatments not available at this facility, you will be provided with a referral to an appropriate provider. When this happens, the facility will share some of your PHI with your new provider, and they will provide this facility with results of their treatment. All of this shared information will become a part of your medical record at each provider location. Your PHI may also be shared with other care providers you may have in the future, who may, in turn, share their treatment information with this facility or other care providers. These are examples of how your PHI is shared for treatment purposes.

For Payment

In order for this facility to be paid for treatment provided to you, your PHI may be used to bill you, your insurance company, or others. You insurance company may require some of your PHI including your diagnosis, treatment(s), expected treatment outcomes, treatment dates/times, treatment details/progress, and other similar things.

For Health Care Operations

Your PHI may also be used in daily business functions of this facility called health care operations. Examples include (1) use in this facility to find areas in need of improvement and (2) when required to disclose your PHI to government health agencies so they may study disorders and treatment for research, your name and identity will be removed from what is disclosed.

Other Uses In Healthcare

Appointment Reminders: Your PHI may be used/ disclosed to remind you of appointments for treatment or other care. If you want restrictions on how you are contacted, simply tell any employee.

Treatment Alternatives: Your PHI may be used/ disclosed to tell you about treatments or other care alternatives.

Other Benefits & Services: Your PHI may be used/disclosed to tell you about health related benefits or services.

Business Associates: Your PHI may be used/ disclosed to other persons, called Business Associates, who do things that we do not do at this facility. All Business Associates sign a contract which includes their agreement to honor your right to privacy.

PHI Use and Disclosure Which Requires Your Authorization

This facility cannot use your PHI for any purpose other than TPO without your permission on an *Authorization for Release of PHI* form. Such Authorizations expire after a certain period of time and can be revoked (canceled) by you, in writing, at any time.

PHI Use and Disclosure NOT Requiring Consents or Authorizations

When Required by Law: Some states, Federal or local laws require that PHI be disclosed.

- Suspected child abuse must be reported.
- A subpoena or other lawful process may require PHI disclosure.
- PHI will be disclosed to government agencies to ensure this facility obeys the HIPAA privacy laws.

Law Enforcement Purposes: PHI may be disclosed to a law enforcement official to investigate a crime or criminal.

Public Health Activities: PHI may be disclosed to agencies who research diseases/ injuries.

Specific Government Functions: PHI may be disclosed to military or veteran benefit programs, to Worker's Compensation programs, or to government agencies for national security reasons.

To Prevent A Serious Threat to Health or Safety: If the staff of this facility believes that there is a serious threat to your health or safety or that of another person or public, your PHI may be disclosed to persons who can prevent the danger.

An Accounting of Disclosures

A record is kept of all PHI disclosures including whom it was sent to, What was sent, and when it was sent. You can get an accounting (a list) of many of these disclosures by requesting it from a staff member.

More Information or Complaints

If you have questions or need additional information, please contact the facility whose name and telephone number are shown on the front of this document.

If you feel your privacy tights have been violated, you have the right to file a complaint with this facility. There will be no retaliation against you for filing a complaint with this facility.

Therapeutic Partners, LLC
60 Louis Prima Ste. A
Covington, LA 70433

Rights & Responsibilities

Getting mental health services is private. We respect your right to privacy. You have, at the very least, the rights and responsibilities listed below.

Your Rights

If you receive services through Therapeutic Partners, LLC, you have the right to:

- Be treated with respect and consideration for your dignity and privacy.
- To select a mental health provider of your choice.
- Be treated fairly regardless of race, religion, gender, ethnicity, sexual orientation, disability or source of payment.
- Have your treatment and other information kept private. Records may be released without your permission only where permitted by law.
- Receive information on available treatment options and alternatives in a way that is appropriate to your condition and easy to understand.
- Receive information and referral to legal representation and various community agencies which may provide support long-term stability
- Share in developing your plan of care.
- Receive information about Therapeutic Partners, LLC, its practitioners, programs, services, and role in the treatment process.
- Receive information about the clinical guidelines used in providing and managing your care.
- Ask providers about their work history and training.
- Not be restrained or secluded to make you do something you do not want to do (as specified in federal regulations on the use of restraints and seclusion).
- Have provider decisions about your care made on the basis of treatment needs.
- Be given health care services that obey state and federal laws that have to do with your rights.
- Participate in decisions regarding your health care. You have a right to self-determination which includes the right to refuse treatment (except when ordered by a court).
- File a complaint/grievance about Therapeutic Partners, LLC, a provider or the care you receive without fear of reprisal.
- Request and receive a copy of your medical records. There may be a charge for the copies to cover cost and labor. Therapeutic Partner's, LLC has the right to deny copies of medical records when providing such records may put the patient at risk.
- Exercise your rights. If you do this, it will not affect the way Therapeutic Partners, LLC and its providers treat you.

Your Responsibilities

Service recipients also have responsibilities with Therapeutic Partners, LLC. Accepting these responsibilities supports your recovery and helps you get the most benefit from your mental health services. It also helps us work with you better. You have the responsibility to:

- Seek treatment that you need from a Therapeutic Partners, LLC provider.
- Treat those giving you care with dignity and respect.
- Give providers and Therapeutic Partners, LLC information they need. This is so providers can deliver quality care, and Therapeutic Partners, LLC can deliver appropriate service.
- Ask your providers questions about your care. This is to help you and your providers understand your health problems and develop treatment goals and plans that you both agree on, as much as possible.
- Follow your treatment plan. You and your provider should agree on this plan.
- Follow the plan for taking your medication that you and your provider agreed on.
- Tell your providers and primary care physician about medication changes. This includes medicines given to you by others.
- Keep your appointment. You should call your provider(s) as soon as you know you need to cancel visits.
- Let your provider know when the treatment plan is not working for you.
- Let your provider know about problems with paying for any required co-pays.
- Openly report concerns about the quality of your care.
- Participate in services without the abuse of alcohol or illicit drugs.
- Report abuse and fraud. You can report concerns by requesting to speak to the Corporate Compliance office or by emailing your concerns to: admin@therapeuticpartners.net

Complaint/ Grievance Process

If, at any time you or a family member believe that your treatment at Therapeutic Partners, LLC is not adequate, safe or in your best interest, you have the following rights which will not in any way serve to compromise your future treatment or access to care:

1. You have the right to voice your complaint expressing your concern regarding the care you receive.
2. You may seek remedy for any complaint.
3. You may complain directly to any staff member.
4. You may submit the complaint in writing and may have assistance in writing the complaint if you are unable to read or write.
5. Staff will initiate an investigation of your complaint within 72 hours of receipt of the complaint.
6. You may request direct access to the Compliance Officer or Chief Administrative Officer at any time during the grievance process.
7. If you believe any of your rights have been violated or you have other concerns about your care in this facility, you may contact one or more of the following:

Department of Health & Hospitals
628 N. 4th Street
Baton Rouge, LA 70802
Phone: (225) 342-9500
Fax: (225) 342-5568

Mental Health Advocate
150 3rd St.
Baton Rouge, LA 70802
Phone: (225) 342-6678

Therapeutic Partners, LLC has a designated Compliance Officer. This person will act on behalf of the patient and/ or family and is responsible for reviewing, investigating, and analyzing all complaints and making recommendations to administration for resolution of all complaints. If at any time you wish to speak to out Compliance Officer you may do so by calling:

Deana Jacob
Email: admin@therapeuticpartners.net
985-327-5427
10a.m.-3p.m. Mon-Fri

You have the right to make a Mental Health Advance Directive:

This document allows you to make decisions in advance about mental health treatment, which includes but is not limited to psychoactive medication, short-term (not to exceed 15 days) admission to a treatment facility, electroshock therapy and outpatient services. The instructions that you include in this directive will be followed only if two physicians believe that you are "incapable", which means that, due to any infirmity, you are currently unable to make or to communicate reasoned decisions regarding your mental health treatment.

Your instructions cannot limit the state's authority to take you into protective custody, or to involuntarily admit or commit you to a treatment facility. Your instructions can be disregarded in an emergency if your instructions have not reduced the behavior that has caused the emergency. In a nonemergency, you may be medicated contrary to your wishes only after an administrative review in which you are provided legal counsel.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint must act consistently with your wishes as expressed in this document or, if not stated, as otherwise known by your representative. If your representative does not know your wishes, he or she must make decisions in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person has the right to withdraw from acting as your representative at any time.

This document will continue in effect for a period of five years unless you become incapable. If this occurs, the directive will continue in effect until you are no longer incapable. You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable.

You may not revoke this advance directive when you are determined incapable by two physicians. A
revocation is effective when it is communicated to your treating physician or other provider.
This advance directive will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature. Also, it must be accompanied by a written mental status examination performed by a physician or psychologist attesting to your ability to make reasoned decisions about your mental health treatment.
If there is anything in this document that you do not understand, please ask for additional information.

MR#:_____

Therapeutic Partners, LLC.

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

I authorize:
Name: _____
Mailing Address: _____
City, State, Zip Code: _____
Relationship: _____ Telephone Number: _____

□ **TO RELEASE Information TO** **OR** □ **TO OBTAIN Information FROM**
(Place an "X" in the box that indicates if the information is being released OR requested)
Name: _____
Mailing Address: _____
City, State, Zip Code: _____
Relationship: _____ Telephone Number: _____ Fax: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*
□ Further Medical Care □ Personal □ Legal Investigation or Action □Changing Physicians
□ Research related treatment □ Creating health information for disclosure to a third party.
□ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

□ Entire Record □ Medical History, Examination, Reports □ Surgical Reports □ Treatment or Tests
□ Prescriptions □ Immunizations □ Hospital Records including Reports □Laboratory Reports
□ X-ray Reports □ MR/DD Records □ Other:_____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

□ Alcoholism □ Drug Abuse □ Mental Health □ Vocational Rehabilitation □ HIV (AIDS)
□ Sexually Transmitted Diseases □ Genetics □ Psychotherapy Notes
□ Other_____

This authorization shall expire on _____ **(date or event) and**
Is needed for the period beginning _____ **and ending** _____ **.**
I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark*) Date

For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

Therapeutic Partners, LLC.

IMPORTANT INFORMATION ABOUT AUTHORIZATION

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of health information for:

- Psychotherapy notes
- Employment-related determinations by an employer
- Research purposes unrelated to your treatment

When required by law or policy, THERAPEUTIC PARTNERS, LLC may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, THERAPEUTIC PARTNERS, LLC will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by THERAPEUTIC PARTNERS, LLC, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to THERAPEUTIC PARTNERS, LLC.

You may cancel an authorization in writing at any time. THERAPEUTIC PARTNERS, LLC can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by THERAPEUTIC PARTNERS, LLC privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how THERAPEUTIC PARTNERS, LLC has used or disclosed information about you. Your benefits will not be affected by any complaints you make. THERAPEUTIC PARTNERS, LLC cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

Therapeutic Partners, LLC
60 Louis Prima Drive, Suite A
Covington, Louisiana 70433
Phone: (985) 327-5427

Email: admin@therapeuticpartners.net

Date: _____ Therapeutic Partners, LLC

Family Satisfaction Survey

Please help us by answering some questions about the services you have received. We really want to know what you think whether it's positive or negative. For each statement, please put a √ under the answer which best describes your opinion. Your answers will be kept confidential. *Thank You for your help!*

Patient Name(Optional): _____

Name/Relation of Person Completing Survey (Optional): _____

	Yes	No
1. The staff member I work most closely with seems qualified		
2. I am satisfied with the program		
3. I feel that the treatment program is beneficial to the above named individual		
4. I would recommend this program to others		
5. I feel that the program staff kept me informed regarding the above named individual		
6. I am satisfied with my level of involvement with the treatment process for my family member		
7. The program staff are helpful in answering questions and/ or addressing concerns I have		
8. I feel this agency is proficient and accommodating in their use of technology		

9. Are there any services not offered by this program which you wish had been available? _____

If so, what services?

_____

_____

9. Would you have preferred less of some services and more of other services?

Please explain._____

_____

Other comments:

_____

_____

Rev 6/12
Rev 11/19
Rev 11/22

Would you like to provide your family member's therapist's name? _____
Would you like this information shared with your family member's therapist? __yes __no

Date:
_____

Therapeutic Partners, LLC

Patient Name (Optional):
_____

Patient Satisfaction Survey:

Please help us by answering some questions about the services you have received. We really want to know what you think, whether it's positive or negative. For each statement, place a √ under the answer which best describes your opinion. Your answers will be kept confidential. *Thank you for your help!*

	YES	*NO*
1. The services helped me improve the way I deal with my problems.		
2. I am satisfied with the agency.		
3. The building and facilities have usually been clean.		
4. I have learned things that will help me.		
5. I would recommend this agency to other people who need help.		
6. I receive enough attention from my therapist.		
7. The services focus on my needs.		
8. The clinical staff person I work with the most closely has been helpful.		
9. The building and furniture are comfortable.		
10. I am treated with respect by the staff.		
11. The staff cares about whether I get better.		
12. This agency is proficient and accommodating in their use of technology		
13. If I were to have problems, I would return to this agency.		
14. Because I came here, I am better able to handle my situation.		
15. I trust the staff at this agency.		
16. I am able to talk with the staff when I need to do so.		

17. Which groups or type of services offered at the program were helpful to you? (check all that apply)
    __ All services
    __ Individual Sessions: __ Home __Office__Telehealth
    __ Medications
    __ Visits with doctor/ nurse practitioner
    __ Neurofeedback with _____

18. Of all the services at the program, which do you feel was most helpful to you? (Please check only one)
    __ Neurofeedback
    __ Medication
    __ Physician visits
    __ Individual Sessions

19. Are there any services not offered at the program, which you wish had been available? If so, what?
    _____
    _____

20. Would you have preferred less of some services and more of others services? Explain.
    _____
    _____

21. Please use any space below to explain any questions you answered "no" above.

Rev 6/12
Rev 11/19
Rev 11/22

Would you like to identify your primary therapist? _____

Would you like us to share your feedback with your primary therapist? _____yes ___No

Therapeutic Partners, LLC

60 Louis Prima Suite A

Covington, LA 70433

985-327-5427 fax: 985-327-8800

Acknowledgements/Consents

Please initial each line and sign below

I acknowledge receipt of Therapeutic Partners, LLC Notice of Privacy Practices and Consent to the uses of my Personal Health Information (PHI) as described within. I also understand the limits of confidentiality as described in the notice, specifically the limits of PHI protection when utilizing text and email communication.

I acknowledge that my client Bill of Rights and as well as my responsibilities for participation in treatment, including procedure to file a complaint or grievance, have been reviewed with me.

I acknowledge receipt of information about Mental Health Advance Directives and have been informed of my rights to formulate a Mental Health Advance Directive.

I HAVE executed an Advance Directive.

I HAVE NOT executed an Advance Directive.

I authorize Therapeutic Partners, LLC to release information to Payors (i.e. insurance companies) as required for billing purposes. I also authorize the insurance companies to pay directly to Therapeutic Partners, LLC, benefits due on my behalf, if any, as provided by my policy.

I understand that if I miss three or more scheduled appointments without calling to cancel or reschedule, it MAY result in termination of services or transfer of care to another clinician.

I understand that 24hr notice is required to avoid a cancellation fee ($35) for appointments scheduled with any of our therapists, psychiatrist, or nurse practitioner. I understand that insurance and third-party payers will NOT cover any portion of this fee. For in-office appointments, 24hr notice is required directly with office staff BY TELEPHONE. Since email or text may not be checked consistently, cancellation of your appointment directly to your therapist, or by email to administrative staff, does not constitute acceptable communication for cancellation of your appointment. I acknowledge this applies to all NON-Medicaid recipients.

I understand that I am responsible for payment at the time services are rendered, including but not limited to previous balance, insurance copayments, and insurance deductibles. My out-of-pocket expense has been estimated and communicated to me prior to engagement in services.

I consent to treatment by Therapeutic Partners, LLC and have had my questions answered so that I understand the above.

If telehealth is recommended as part of my behavioral health treatment, I acknowledge that I have been made aware of its' benefits and limitations. I further acknowledge the risks and limitations with confidentiality and agree to assume responsibility for ensuring confidentiality is upheld to my standards if my own personal device is used. I also acknowledge that I have a right to refuse Telehealth and that this refusal may impact my ability to access certain mental health services through Therapeutic Partners, LLC

I acknowledge I have received information in regard to 24 hours access to care.

I consent to my photograph being taken for the sole purpose of identification in my client record

I acknowledge that Therapeutic Partners, LLC health and safety policies regarding use of seclusion and restraint, use of tobacco products, legal/illegal substances, prescription medication, and weapons brought onto the premises, has been provided to me.

I acknowledge that I have been informed on the importance of my role in developing my treatment plan goals, my potential course of services, expectations for legally required appointments, how my family may be involved, and the potential use of motivational incentives.

I request the following people to participate in my/my child's treatment. This may include participation during session, signing of treatment plans, coordination of visits, and any other activity beneficial to the progression of my/my child's treatment.

1.

2.

3.

Therapeutic Partners, LLC
60 Louis Prima, Covington, LA, 70433
Phone # : 985-327-5427

Telehealth Informed Treatment

1. I understand that my/my child's health care provider may offer for me to engage in a telemental health consultation.

2. My health care provider has explained to me the way the video conferencing technology will be used and that it will not be the same as a direct patient/health care provider visit, due to the fact that I/my child will not be in the same room as the health care provider.

3. My health care provider has explained to me the rationale for using telehealth in place of in-person services.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my/my child's health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. In the event that I am receiving telehealth at a Therapeutic Partner's facility and my provider is at another location, I understand that others may also be present on site during the consultation in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

6. In the event that I/my child participates in telemental health from a preferred offsite location, I assume the risks and responsibilities of ensure a safe and confidential setting for my/my child's session.

7. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

8. In an emergent consultation, I understand that the responsibility of the telemedicine provider is to ensure that emergency response is coordinated specific to my region.

9. I have had a direct conversation with my doctor/treatment provider, during which I had the opportunity to ask questions in regard to this procedure.

10. Should I choose not to receive treatment via telehealth, and there are no other treatment options available through Therapeutic Partners, I acknowledge that I have been informed of the risks and benefits of receiving no treatment. I further acknowledge that, upon request, I will receive referrals for mental health services that may be available face to face.

11. I agree that informed consent can be found in the provider's Consents/Acknowledgements form signed upon admission/orientation and annually thereafter

Therapeutic Partners, LLC.

Acknowledgements/Consents

Medication Management Addendum

I understand that prescriptions are not guaranteed for **missed** or **cancelled** medication management appointments.

- For clients seen monthly or bi-monthly: you will be allowed one missed or cancelled appointment with one (1) medication refill every six months.
    - After that, no more refills will be given until you meet with the nurse practitioner or doctor.
- For clients seen quarterly: you will be allowed one missed or cancelled appointment with one (1) medication refill every twelve months.
    - After that, no more refills will be given until you meet with the nurse practitioner or doctor.

I understand that if I no show more than two medication management appointments in a twelve month period, I will be medically discharged.

I also understand that I must be compliant with therapy in order to receive medication management services.

Personal Medication

Clients may bring their personal prescribed medication on-site. However, the agency shall not be responsible for medications self-administered by the client, both on and off site. Additionally, clients shall be educated during Client Orientation, about the proper handling of their personal medications and belongings while in Therapeutic Partners, LLC facility. *Personal items should never be left unattended and when possible, personal medications should be left in the client's locked vehicle*

Prohibited Items

Use and/or possession of weapons (except for law enforcement), illicit drugs, alcohol, and tobacco are prohibited at this facility.

If anyone (staff, client, or visitor) presents a weapon, or prohibited item, the staff has procedures in place to ensure the safety of all persons on the premises.

It is a safety risk to allow a client and/or visitor to be on the premises under the influence of legal or illicit drugs and/or alcohol.

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from **one provider** unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711

2. Amerihealth Caritas Louisiana: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588

3. Healthy Blue: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)

4. Louisiana Healthcare Connections: https//providersearch.louisianahealthconnect.com/ or call 1-866-595-8133(Hearing Loss: 711)

5. United Healthcare Community: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

6. Humana Healthy Horizons: https://finder.humana.com/finder/medical?customerId=1 or call 1-800-448-3810 (TTY: 711)

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider Name:	Therapeutic Partners, LLC.
Provider Phone Number:	(985) 327-5427
Provider Contact Name:	Emily Cox, Office Manager
Provider Address:	60 Louis Prima Drive Suite A Covington, Louisiana 70433

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

24-Hour Access to Services

1. All clients have access to 24-hour emergency consultation and brief intervention services that MAY include direct contact and/or consultation with the psychiatrist and/or psychiatric nurse.

2. After hours, clients are able to access emergency services by calling the main office number. When a voicemail message is received and considered emergent, a return phone call is made to the client immediately to assess the situation. If necessary, the on call psychiatrist is contacted by the LMHP.

3. All crisis situations are assessed by a licensed mental health professional via face to face evaluation and/or telecommunication.

Therapeutic Partners, LLC contact information:

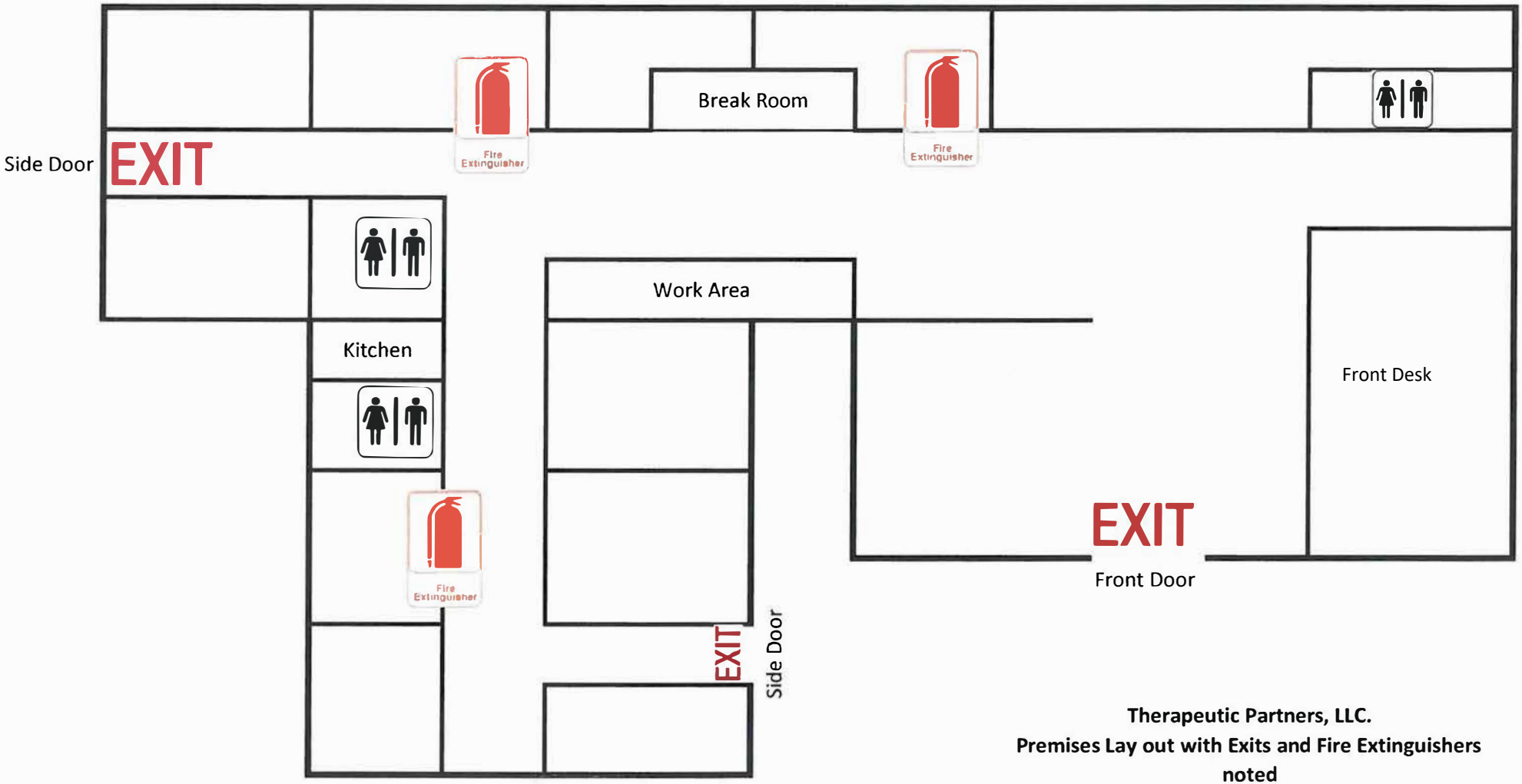
Main Office
60 Louis Prima Dr., Ste. A
Covington, LA 70433

Phone: 985-327-5427
Fax: 985-327-8800

Hours of Operation
9:00 am to 4:30 pm
Monday thru Thursday
9:00 am to 3:00 pm
Friday
Additional Hours by Appointment Only

Emergency Services
24 Hours a Day, 7 Days a Week
985-327-5427

Email Address:
admin@therapeuticpartners.net



Therapeutic Partners, LLC.
Premises Lay out with Exits and Fire Extinguishers noted