

Informed Consent and Admission Agreement

I am consenting to voluntarily participate in this program with The Bridge. I have been informed about what to expect and I have been given the opportunity to give or withhold this consent prior to the delivery of services by The Bridge. I understand that I may leave this program at any time, although I have been informed that this is best accomplished by discussing it with my counselor, therapist, case manager, program manager, family and/or attorney.

I understand that this admission is of a confidential nature. I understand that The Bridge may not communicate about my contact with the agency as a client with any person or agency without first receiving my consent. I understand that there are limits to this confidential relationship that include:

- 1) a duty to warn others in the event that I have made a threat to harm another person
- 2) a duty to report suspected child abuse
- 3) information that is ordered by the court for just cause to be entered into evidence for civil or criminal court proceedings
- 4) information necessary to receive third party payments.
- 5) internal program communication
- 6) medical emergencies or treatment requirements
- 7) audits and evaluations by outside parties

I understand that this program may involve discussing relationships, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me and my family become healthier.

I agree to possible drug screening, searches by a person or wand of my body and/or my belongings at admission and throughout my time in the program for the purpose of ensuring a safe, weapon-free and alcohol/drug-free environment. I have the right to refuse these procedures, but I may be subject to discharge due to concerns for the safety of others.

I understand that a component of the program at The Bridge involves physical activities that may include, but are not limited to the following: participation in community service, organized sports, recreation and trips related to civic, cultural, and educational functions. Additionally, I understand and agree that active participation is required in all areas of the program including individual and group therapy; goal setting and treatment planning.

I understand that at times it may be necessary to be transported to and/or from activities associated with The Bridge, Inc. program(s). When/if I am transported, I do hereby release The Bridge, Inc., as well as its directors, officers, administrators, employees or other agents from all liability or damages for any and all injuries or issues arising from the negligence by any of the above while traveling to and/or from any Bridge program associated activity via Bridge transportation.

I understand that I will receive educational services regarding HIV and AIDS and, if I choose, testing and possible treatment services will be provided by the local health department.

I understand that I will be screened for tuberculosis risk and may be referred for testing and possible treatment by the local health department.

Consent for Use, Disclosure and Notice of Privacy of Health Information

Purpose of Consent

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. The content herein is our privacy practices and provides a description of how we will use and/or disclose your health information. If you want more information about our privacy practices or have questions or concerns, please contact us.

We reserve the right to change our privacy practices; which may apply to any of your protected health information that we maintain. If we change any of the content of this consent, we will provide you the revised notice with the changes.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

Use and Disclosure of Health Information

If we use and/or disclose health information about you for treatment, payment and healthcare operations it could be as follows:

Treatment

We may use and/or disclose your health information to a counselor, physician or other healthcare provider providing treatment to you.

Payment

We may use and/or disclose your health information to obtain payment for services we provide to you. You should provide us a correct mailing address by which we may contact you.

Healthcare Operations

We may use and/or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, licensing, certification, accreditation, or credentialing activities.

With Authorization

In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Family

We may disclose your health information to a family member to the extent necessary to help with your healthcare or for payment, but only if you provide written agreement that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use and/or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in forwarding to another person filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing

We will not use your health information for marketing communications without your written authorization.

Without Authorization

Required By Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if you report or we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions (such as, juvenile or adult court officials, probation or probation officers, judges) having lawful custody of protected health information of inmate or clients under certain circumstances.

Patient Rights

Access

You have the right to see your clinical record in the presence of a Director if you provide a written request. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you 75 cents for each page, \$8.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information at no charge.

Disclosure Accounting

You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for a minimum of the last six (6) years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice

If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form if you request it.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the privacy officer, advocate or state department associated with your program.

Client Legal and Human Rights

My legal and human rights during my time in this program with The Bridge are:

To not be denied treatment based on my ability to pay. I will be informed of all fees associated with treatment and the consequences of nonpayment. I have the right to manage my personal financial affairs unless legally determined otherwise.

To receive treatment and care in a safe environment; one that is absent of physical abuse, sexual abuse, harassment, physical punishment, psychological abuse, threats, exploitation, coercion, or fiduciary abuse. To report without fear of retribution any instances of perceived abuse, neglect, or exploitation. Any cases of suspected abuse, neglect, exploitation of clients, regardless of age, being served in the program where the alleged perpetrator is an employee, client, or other person in the program will be reported to the local DHR office and other entities in accordance with applicable State law and abuse reporting procedures.

To the provision of services in a manner that is respectful and responsive of the client's unique characteristics, needs and abilities. To receive from all employees of the agency, at all times, under all circumstances considerate, respectful, humane, adequate, and appropriate care.

To be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatments, services, and/or providers.

To receive the least restrictive treatment that is appropriate and available. Clients will also have the right to refuse treatment. If this occurs, the client will be informed of other appropriate substance abuse providers from which they may seek services. The client will actively participate in treatment, including discharge planning, as appropriate.

To receive accurate, easily understood information at all times, during every aspect of service delivery, and to participate fully in all decisions related to treatment and care provided by the Bridge. This includes, but is not limited to: development of an individualized treatment plan formulated in partnership with the program's staff, to receive services based upon that plan within the least restrictive environment possible, to provide input regarding the service delivery processes through the outcome questionnaire

To the availability of an adequate number of competent, qualified, and experienced professional clinical staff to ensure appropriate implementation of the client's treatment plan and that the provision of care meets or exceeds accepted clinical practice standards.

To have my presence in treatment kept confidential except when I have given written authorization to release information or in the event of an emergency in which information must be released. Internal access to files is limited to the clinical and administrative staff of the program. External access to files is limited to the program's certification site visit and information that must be released if subpoenaed by the court and ruling of "good cause" is issued.

To not be recorded by hidden cameras or audio/visual equipment (i.e. one way mirrors or hidden cameras). Cameras are utilized in the residential programs for client protection and security. The Bridge is often used as a training site for local universities and audio/video maybe used for training and educational purposes with informed consent from client and legal guardian.

To submit a grievance in accordance with The Bridge, Inc. grievance policy. A client may also contact Advocacy Services with the Department of Mental Health, the Department of Youth Services, the Privacy Officer and/or the US Department of Health and Human Services.

To participate in any spiritual service voluntarily. We honor and respect the religious and spiritual differences of our clients and will work to provide each person access to opportunities with the God/Higher Power of their understanding.

By signing below I am confirming that I have read and understand the information presented and I am consenting to participate in the program offered to me by The Bridge. If I have further questions, I understand that my primary therapist will either answer them or find answers for me. I am also confirming that staff has discussed the preceding documents with me and I understand the information presented. My signature below indicates I've received and reviewed the following documents.