Patient #

Behavioral Health Consumer Orientation Checklist

☐ Behavioral Health Consent for Treatment Form (BH-002-F20)

☐ Right to Name Treatment Advocate (BH-027-F19) ☐NA

☐ Consent of Protected Health Information (REG-010-F6)

☐ Consumer Handbook and Acknowledgment of Receipt (BH-027-F21)

☐ Bio-Psychosocial Assessment (Intake Assessment)

☐ Stigler Health and Wellness Center, Inc. Pamphlet

Is Stigler Health and Wellness Center, Inc. collaborating with another agency or LBHP provider regarding this consumer? ☐ Yes ☐ No

If yes, who? _____

After your intake is completed we will develop a treatment plan using the information you give us about your preferences and needs. Your therapist will go over this plan with you, including the discharge criteria, when it is ready to sign.

The use of the Patient Portal to communicate with the consumer's provider shall be for non-emergent purposes. If there is an emergency consumers should call 911 or seek help at their local health care emergency facility.

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist and Stigler Health and Wellness Center, Inc. to submit claims for all benefits, for services rendered and for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Printed Name of Consumer Date Signature of Consumer Date

_____ _____

Printed Name of Parent/Guardian Date Signature of Parent/Guardian Date

_____

Signature of Witness (Clinician) Date

Behavioral Health Consent for Treatment

Application is hereby made by the undersigned for voluntary admission to the services of Stigler Health and Wellness Center, Inc. outpatient behavioral health services.

I certify that I am eighteen years of age or over. Voluntary admission may be made for any person eighteen (18) years of age or over on his/her own signature. Any person at least 14 years of age may be admitted with the consent of such person and the consent of the person's parent or guardian.

All persons receiving services from this facility shall retain the rights, benefits, and privileges guaranteed by the laws and constitution of the State of America, except those specifically lost through due process of law. OS 43A, Section 1-103(h).

- All persons shall have the rights guaranteed by the Substance Abuse Consumer's Bill of Rights, unless and exception is specifically authorized to these standards or an order of a court of competent jurisdiction.
- I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered.

I understand that OS 43A, Section 4-201 requires that each consumer of the agency be charged for care and treatment provided. An individual will not be refused needed treatment because of inability to pay, OS 43A, Section 4-202.

Date of Birth: _____ Patient #: _____ ○ Male ○ Female

Address: _____ County: _____

City, State, Zip: _____

Primary Contact#: _____ Secondary Contact #: _____

Guardian Name: _____

Guardian Phone Numbers: _____ Relationship to consumer: _____

Emergency Contact: _____ Emergency Phone #: _____

Referred By (parent, school, self, ect.): _____

Race:

○ White

○ Black/African American

○ American Indian

○ Asian

○ Native Hawaiian/ Pacific Islander

Ethnicity

○ Hispanic/Latino

Name & credentials of all clinicians that will be providing services:

Individual: _____ Family: _____ Group: _____

_____ _____

Printed Name of Consumer Date Signature of Consumer Date

_____ _____

Printed Name of Parent/Guardian Date Signature of Parent/Guardian Date

_____

Signature of Witness (Clinician) Date

Client Name: _____ Date _____Patient #: _____

Patient Questionnaire

Thoughts and Behaviors – (Adult)

Please check (√) how often the following behaviors occur:

	Never	Rarely	Sometimes	Frequently
1. Life is hopeless.				
2. I am lonely.				
3. No one cares about me.				
4. I am a failure				
5. Most people don't like me.				
6. I want to die.				
7. I want to hurt someone.				
8. I am so stupid.				
9. I am going crazy.				
10. I can't concentrate.				
11. I am so depressed.				
12. God is disappointed in me.				
13. I can't be forgiven.				
14. Why am I so different?				
15. I can't do anything right.				
16. People hear my thoughts.				
17. I have no emotions.				
18. Someone is watching me.				
19. I am out of control.				
20. I feel that others are out to get me.				
21. Shy/Avoidant/Withdrawn				
22. Mood shifts.				
23. Do things without thinking.				
24. Irritable				
25. Impaired judgment.				
26. Forgetfulness				
27. Panic attacks				
28. Excessive worries, phobias, fears.				
29. Confusion.				
30. Crying spells.				

Client Name:	Patient #:

SCREENING AND INITIAL ASSESSMENT (Part I)

1. Why have you contacted us? What problems are you having? What are you hoping to get out of treatment?_____

_____

_____

2. How long have the problems you mentioned been bothering you?
1 week ☐ A few weeks ☐ A month ☐ A few months ☐ 1 year or more ☐ Unknown ☐

Yes ☐ No ☐ 3. Are you currently taking medication for mental health reasons?
If yes, please list: _____

Yes ☐ No ☐ 4. Are you currently out of mental health medication?

Yes ☐ No ☐ 5. Have you ever been a member of a Day Treatment or Clubhouse Program?

Yes ☐ No ☐ 6. Have you ever been hospitalized for mental health reasons?
If yes, name of hospital_____Diagnosis:_____Date:_____

Yes ☐ No ☐ 7. Have you ever been a client at a mental health clinic?
If yes, which mental health clinic?_____

Yes ☐ No ☐ 8. Do you feel if you are not seen today, you may hurt yourself? How? _____

Yes ☐ No ☐ 9. Do you feel if you are not seen today, you may hurt someone else?

If yes, who?_____

Yes ☐ No ☐ 10. Are you hearing noises or voices that others do not hear? What? _____

Yes ☐ No ☐ If voices, do they tell you to harm yourself or others?

Yes ☐ No ☐ 11. Are you seeing persons or things that are not there or that others do not see? What? _____

Yes ☐ No ☐ 12. Are you experiencing withdrawal symptoms from alcohol or other drugs?
If yes, please list drug(s) and symptoms:_____

Yes ☐ No ☐ 13. Are you currently a victim of sexual or physical abuse?

If yes, when were you last abused?_____

Yes ☐ No ☐ 14. Have you in the recent past or present experienced any pain?
If yes, where is/was the pain located?_____

_____ _____
Clinician Signature Date

Client Name:

Patient #

Health and Medication History

Yes ☐ No ☐ Are you taking any medications (prescribed, as well as "over the counter") at the present time?

If yes, please list:

NAME OF MEDICATION	PURPOSE	STRENGTH/DOSAGE	PRESCRIBED BY	DATE BEGAN	HOW IT HELPS YOU	SIDE EFFECTS

Yes ☐ No ☐ Are you presently being treated for a medical or surgical problem?

If yes, please explain:_____

Who is your personal physician(s)?_____ Date of last physical exam:_____

Do you use tobacco? Yes ☐ No ☐ Pack/day___/___ Other:_____

Do you use alcohol? Yes ☐ No ☐ How much_____ How often_____

Do you use street drugs? Yes ☐ No ☐ IV Drug use? Yes ☐ No ☐ Date of last use?_____

What type(s)_____ How often_____

Yes ☐ No ☐ Have you had any recent change in appetite/weight gain or loss? If yes, please explain

_____

_____

_____

Yes ☐ No ☐ Have you had any recent change in sleeping patterns? If yes, please explain _____

_____

_____

Yes ☐ No ☐ Do you use any assistive technology devices such as a pacemaker, hearing aid cane, etc:

If yes, please list:_____

_____

_____ _____

Client (Guardian) Signature Date

_____ _____

Clinician Date

CONSENT OF PROTECTED HEALTH INFORMATION

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease. I understand that the information requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse Patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA'), 45 C.F.R. Parts 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal Law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulations. I understand that treatment services are NOT contingent upon or influenced by my decision to permit the release of information. I further understand that if the organization or person authorized to receive this information is not required to comply with the Federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

Please identify the person or persons you authorize your Protected Health Information (oral or recorded information) to be released to by Stigler Health and Wellness Center, Inc. (SHWC).

This may include your spouse, parents, siblings, children, friends or guardian. Please list below:

NAME	RELATIONSHIP	HOME PHONE #	CELL PHONE #

Stigler Health and Wellness Center, Inc. is required to have your permission to leave messages regarding your Protected Health Information (test results, instructions, appointment reminders, etc.)

Please check the appropriate boxes:

_____ **Yes,** SHWC **may** leave a message on my answering machine/voice mail regarding my Protected Health Information.

Comments: _____

_____ **No,** SHWC **may not** leave a message on my answering machine/voice mail regarding my Protected Health Information

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Patient

_____ _____

Patient # Patient Name

This authorization shall remain in effect until revoked.

Right to Name a Treatment Advocate

All adult behavioral health patients being served by a licensed behavioral health professional have the right to designate a family member or other concerned individual as a Treatment Advocate. The choice to name an advocate is the patient's alone. In the event an advocate is chosen, the level of involvement of the advocate is to be determined by the patient and no limitation may be imposed on the patient's right to communicate by phone, mail or visitation with the established Treatment Advocate. The Treatment Advocate may participate in the patient's treatment planning and discharge planning of the person being served to the extent consented to by the patient and permitted by law.

Would you like to name a treatment advocate? ____Yes _____No

Please list the name and phone number of the person you wish to choose as a Treatment Advocate:

Name: _____ Phone (Include area code): _____

Please indicate the level of involvement the identified Treatment Advocate shall have:

__ Should the Advocate be present during intake?

__Would you like the advocate to help you with treatment planning?

__Do you want the written treatment plan information provided to the advocate?

__Should we notify the advocate only if there are changes to the treatment plan?

__Would you like the advocate to be present at all of your sessions?

__Other: _____

_____

_____ _____

Patient Signature Date

For the Treatment Advocate:

I intend to serve as Treatment Advocate for the above named patient. I have received a copy of the Health and Wellness Center confidentiality standards and I agree to serve according to the patient's specifications and comply with all standards of confidentiality.

_____ _____

Treatment Advocate Signature Date

The patient may revoke the designation of a treatment advocate at any time and for any reason.

_____ _____

Clinician Signature Date

Patient Name:	**Patient #:**

Behavioral Health Services

Patient Handbook

Stigler Health & Wellness Center, Inc.

Table of Contents

Dear Patient,

Thank you for allowing our qualified staff to care for you as you pursue your goals towards a healthy, rewarding and productive life. We at Stigler Health and Wellness Center, Inc. (HWC) are dedicated to empowering you reach your individual goals for health and well-being.

It is our mission at HWC to improve the quality of life for persons in Oklahoma. We are committed to providing quality health care services for all area patients.

As part of your care, many issues will be discussed. A thorough assessment will be completed to help identify your goals, preferences and needs. The assessment generally consists of questions regarding several aspects of your life.

From the information gathered, an individual care plan will be developed, with your assistance, to identify specific goals you wish to achieve with your treatment team. These mutually identified goals and objectives may addressed in a variety of settings which could include Individual, Family and Group Therapies, Please notify our staff if you are in need of a specific service.

Typically, patients discharge from services when your individual goals are met. Your treatment team will begin discussing discharge criteria with you upon admission so that all involved can remain focused on problem resolution. If at any time during your course of treatment you feel that you would like to discontinue services, please notify someone on your treatment team so that they can inform you of the transition procedures.

Listed below is the contact information for the office location of HWC administrative office hours are 8am to 5pm. If you have an after-hours life threatening emergency, please call 911 or go to your closest emergency room.

You can find additional information regarding HWC on our website at www.thwcinc.com.

Administrative Hours of Operation: 8am-5pm

Clinician Hours: Varies

Stigler, OK	Eufaula, OK	Poteau	Sallisaw
Phone- 918.967.3368	918.689.3333	918.647.2155	918.790.2653

Checotah, OK	Wilburton, OK	Warner, OK
Phone-918.473.0048	918.465.0005	918.463.2837

Provider Clinician Name: _____

Provider Clinician Contact # _____

Each of our clinics has a local advocate to assist you with problems, grievances or any other issues. The local advocate's name and contact information is posted on the wall of the clinic. The individuals with the authority to make decisions on grievances for behavioral health complaints is the HWC CQI Coordinator and the Behavioral Health Department Director. These individuals may be reached by calling 918.967.3368.

A. MISSION STATEMENT:

Stigler Health and Center, Inc. is committed to providing quality health care services for all area patients.

B. CODE OF ETHICS

HWC therapists adhere to their Licensing Board Code of Ethics.
The Code of Ethics and Standards of Practice of the American Counseling Association is a lengthy document which has been condensed for your information as a summary of ethics with which. HWC will comply. If at any time you would like a copy of the complete Code of Ethics, please contact our office at 918.967.3368 and one will be mailed to you.

- Counselors respect diversity and must not discriminate against patients for any reason.
- Counselors must make every effort to avoid dual relationships with patients.
- Counselors must not engage in any type of sexual intimacy with patients.
- Counselors must take steps to protect patients from trauma resulting from interactions during group work.
- Counselors must terminate any counseling relationship if it is determined that they are unable to be of assistance.
- Counselors must keep information related to counseling services confidential, except in very specific circumstances.
- Counselors must not disclose information about one family member in counseling to another family member without prior consent.
- Counselors and staff must maintain confidentiality with all records at all times.
- Counselors must obtain permission before recording sessions or transferring records.
- Counselors must not engage in sexual harassment or receive any unjustified personal gains, goods or services.
- Counselors must communicate to group members that confidentiality cannot be guaranteed in group work.

C. PATIENT RIGHTS

Each patient has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.
(1) Each patient shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
(2) Each patient has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation. This non-discrimination policy specifically includes but is not limited to HIV infection and AIDS.
(3) No patient shall be neglected or sexually, physically, verbally, or otherwise abused.
(4) Each patient shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A patient shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those patients adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each patient shall have the right to the following:
(A) Allow other individuals of the patient's choice participate in the patient's treatment and with the patient's consent;
(B) To be free from unnecessary, inappropriate, or excessive treatment;
(C) To participate in patient's own treatment planning;
(D) To receive treatment for co-occurring disorders if present;
(E) To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
(F) To not be discharged for displaying symptoms of the patient's disorder.
(5) Every patient's record shall be treated in a confidential manner.
(6) No patient shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the patient.
(7) A patient shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

(8) Each patient has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
(9) No patient shall be retaliated against or subjected to any adverse change of conditions or treatment because the patient asserted his or her rights.
(d) Each affected facility and program shall have written policy and implementing procedures, and shall provide documented staff training to insure the implementation of each and every patient right stated in this Chapter.
(e) Each affected facility and program shall have written policy and implementing procedures to insure each patient enjoys, and has explained to him or her, these rights, and these rights are visibly posted in both patient and public areas of the facility.
(f) The ODMHSAS Office of Patient Advocacy and the ODMHSAS Office of the Inspector General, in any investigation or monitoring shall have access to patient, facility or program records and staff as set forth in this Chapter.
(g) All facilities that are certified by, operated by, or contracted with the Department shall post the contact information for the ODMHSAS Office of Inspector General and ODMHSAS Office of Patient Advocacy prominently in public and patient treatment areas.

The above rights are meant as a synopsis of the Mental Health and Drug or Alcohol Abuse Services Bill of Rights. A full copy of the rights, OAC 450:15-3-6 through 450:15-3-27, is available upon request.

D. CONFIDENTIALITY OF PATIENT RECORDS

The confidentiality of patient records is protected by Federal Law and Regulations and Oklahoma Statutes. Information and/or copies of records concerning past or present treatment or services provided by HWC to the above referenced patient will not be disclosed to third parties unless:

1. The patient, or those authorized by Federal or State law, consents by written authorization to HWC for the release of such information to a third party.
2. The disclosure is ordered by a court of competent jurisdiction and a copy of said order is provided to HWC in advance of the HWC disclosure.
3. The clinician has a "duty to warn" in the event there is a dangerous situation, in the opinion of the clinician, and the patient and/or others are considered to be in danger.

Federal Laws and Regulations and Oklahoma Statutes do not protect any information concerning suspected child abuse, domestic violence, elder abuse or neglect from being reported under State law to appropriate State or local authorities. In crisis situations in which a patient is at imminent risk of harming him/herself or others, and a no-harm contract is not feasible, local law enforcement and/or the state contracted gatekeeper for inpatient treatment may be contacted without prior authorization from the patient.

Violation of the Federal Law and Regulations and/or Oklahoma Statutes is a crime. Suspected violations may be reported to appropriate officials. (See 42 U.S.C. 290 dd-3 and 42 U.S.C. 290 ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.)

HWC adheres to all governmental requirements. You have the right to privacy and HWC will safeguard your privacy. HWC has developed a patient privacy process that will guard your personal information. If, for any reason, you believe the HWC has violated your right to privacy as a patient you can file a formal complaint to the following.

Office of Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Phone: (214) 767-4056
Fax: (214) 767-0342

Please rest assure that HWC values you as a patient and will make every effort to ensure confidentiality in all applicable areas as this is our priority.

E. RECORDING TREATMENT SESSIONS

To ensure the confidentiality and privacy of patient records, no treatment encounter shall be recorded by video or audio by any party without the written consent of each individual in the session.

F. PATIENT NOTICE OF HEALTH INFORMATION PRACTICES (HIPAA) and 42 CFR

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

General Information
Information regarding your health care, including payment for health care, is protected by two federal laws:

- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 42, U.S.C., §1320d et. seq., 45 C.F.R. Parts 160 & 164, and the
- Confidentiality Law 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2.

Under these laws, HWC may not say to a person outside HWC that you attend the program, nor may HWC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

HWC must obtain your written consent before it can disclose information about you for payment purposes. *For example*, HWC must obtain your written consent before it can disclose information to your pay source in order to be paid for services. Generally, you also sign a written consent before HWC can share information for treatment purposes or health care operations. However, federal law permits HWC to disclose information ***without*** your written permission in the following instances:

- Pursuant to an agreement with a qualified service organization/business associate;
- For research, audit or evaluation;
- To report a crime committed on HWC's premises or against HWC personnel;
- To medical personnel in a medical emergency;
- To appropriate authorities to report suspected child abuse or neglect;
- As allowed by a court order.

For example, HWC can disclose information without your consent to obtain legal and financial services, or to a medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before HWC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Patient Rights Regarding Health Information
Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. HWC is not required to agree to any restrictions you request, but if it does agree it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. HWC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health care information maintained by HWC except to the extent that the information contains counseling notes or information compiled for use in a civil, criminal or administrative hearing or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in HWC records, and to request and receive an accounting of disclosures of your health related information made by HWC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Duties of the Organization
HWC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. HWC is required by law to abide by the terms of this notice. HWC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Such changes will be communicated to present patients through provision of a copy of the revised notice. Former patients making appropriate requests will be provided a copy of the updated notice at the time of request.

Reporting Complaints and Violations
You may complain to HWC and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. Such complaints should be pursued through the established HWC Grievance Procedure. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States District Attorney in the district where the violation occurs. For further information, you may contact an administrator for Stigler Health and Wellness Center Inc. at 918.967.3368.

G. COMPLAINT/GRIEVANCE/APPEAL PROCEDURE

If you ever have a problem with any of the employees or the functioning of HWC it is asked that you address it with the local HWC patient advocate or file a grievance report. This serves two purposes; first it allows us to correct the problem, and second, this information will be used to determine trends and areas needing performance improvement. You also have the right to file your grievance directly with the ODMHSAS Office of Consumer Advocacy at P.O. Box 151
Norman, OK 73070, E-mail: advocacydivision@odmhsas.org, or phone: 405-573-6605, 1-866-699-6605.

HWC's procedures concerning formal complaints is as follows:

- It is the patient's responsibility to document the occurrence on a form provided by HWC.
- The form is to be delivered to the local patient advocate whose name is posted in the clinic.
- The form must be received within 10 business days of the occurrence.

- In the event that the patient is unable to complete the form, they may contact the patient advocate, a clinic supervisor, or the COO in order to make the complaint.
- HWC's Continuous Quality Improvement Coordinator addresses all complaints and grievances. The CQI Coordinator and Behavioral Health Director are responsible for decision making regarding the resolution of the complaint/grievance within the Behavioral Health Department. Interviews and investigation of each grievance will be conducted in a manner specific to each occurrence as needed. In the event that the CQI Coordinator or Behavioral Health Director is the subject of the complaint / grievance, the HWC Chief Operating Officer will be responsible for the resolution of the grievance.
  Resolution of the complaint / grievance shall be made within 14 days upon receipt of the form, and a copy of the determination shall be mailed to the patient.
- If the patient is not satisfied with the resolution, he/she has the right to appeal the determination of the grievance, in writing, within 10 business days of the notification. The COO will then be responsible for contacting an external Human Resource vendor for a comment on the determination.
- If the patient remains unsatisfied with the resolution, he/she has the right to contact the previously mentioned Office of Patient Advocacy at ODMHSAS.

Filing a grievance or complaint shall not result in retaliation or barriers to service. All parties in the complaint/grievance process have rights and responsibilities. During the investigation process, an individual who is the subject of the grievance has the right to:

- Be advised of the nature of the allegation
- Be advised of the investigative process
- Be interviewed by any involved Advocate and allowed to give his or her position regarding the allegation.
- Submit a written statement relating to the allegation
- Seek advice from other parties concerning rights and responsibilities in Office of Patient Advocacy investigations.

An individual accused through the complaint/grievance process shall:

- Be available and accommodating for interviews
- Refrain from any action which interferes with the investigation
- Provide pertinent information and respond fully and truthfully to questions asked
- Refrain from intentionally misdirecting the investigation

H. PATIENT ORIENTATION INFORMATION

After Hours Access:
HWC offers after hour access by telephone for crisis situations. This service is accessible by calling the main clinic number. In the event you or someone else is experiencing an imminent safety risk, it is strongly recommended that you contact local emergency personnel (i.e. 911, police, ambulance, etc.)

Custody or Divorce Actions:
HWC therapists do not testify in court regarding custody or divorce actions. Custody evaluations and expert testimony require a specific procedure and relationship with the client that is different from a therapeutic relationship. It is in fact, unethical for the therapist to move from a therapist's role to one of advising the court regarding the fitness of a parent or the child's needs concerning who would be the "best" parent. Should the need arise for this type of evaluation and testimony, we will be happy to refer you to independent psychologists we have found to be expert in this area of service. Because the great risk of malpractice suits and because we do not see it as appropriate to participate in these cases, a

minimum fee of $1,500 per half day or less out of the office will be assessed should we be legally required to testify in any court proceeding. We ask that you respect this professional boundary.

Use of Tobacco Policy
Due to the acknowledged hazards arising from the use of tobacco products, it is the policy of HWC to provide a tobacco-free environment for all employees, patients and visitors. This policy covers all forms of tobacco products and applies to both employees and non-employee visitors of HWC. This policy serves as a condition of employment.

DEFINITIONS

- There will be no use of all forms of tobacco products, electronic cigarettes, and other vapor delivery devices within the facilities or on the property 24 hours a day, seven days a week.
- This policy applies to all employees, volunteers, clients, visitors, vendors, and others on business at HWC 24 hours a day, seven days a week.
- There will be no tobacco use in personal vehicles 24 hours a day, seven days a week while on or around HWC property during work duty hours.
- There will be no tobacco use in worksite vehicles 24 hours a day, seven days a week.

Seclusion and Restraint
HWC does not use any methods of seclusion, restraint, restriction of rights or special treatment interventions of any kind under any circumstances, including emergency holds.

SAFETY MANAGEMENT PROGRAM
RESTRICTION OF WEAPONS IN FACILITIES POLICY
It is the policy of the administration of HWC, that possession of weapons, including legally owned guns, is prohibited on the premises of the Clinics and its managed properties. EXCEPTION: Officers of City, County, State and Federal Law Enforcement agencies.

Health, Safety and Licit/Illicit Drugs
If it becomes apparent that a patient presents themselves as under the influence of drugs or alcohol during a counseling session and interferes with cognitive functioning to receive proper treatment, they will be asked to leave HWC property If anyone comes onto HWC property with licit or illicit drugs, the police will be called immediately.

If you have any questions, concerns, or comments regarding this information, please contact the HWC CQI Coordinator, Kayla Wright at (918)-967-3368.

I. PATIENT EXPECTATIONS

Due to the importance and need for the full allotted time in quality health care it is necessary to keep regularly scheduled appointments. In order for your time services to be as productive as possible, it is asked that you agree to these stipulations:

- Keep scheduled appointments with all our Clinicians.
- Be prompt for your appointments.
- If you cannot make an appointment, give at least 24 hour notice.

If you fail to show up or call for scheduled appointments more than 3 times, it will be assumed that the services we are providing are not appropriate or effective for you and we may refer you to another agency or discontinue services.

Other expectations:

- Upon termination we need at least one session to discuss that decision.
- If you have not seen your family doctor, or had a physical checkup in the last year, it is recommended that you do so.
- You may be asked to participate in surveys periodically. This information will be utilized to ensure quality of care, achievement of outcomes, and to measure patient satisfaction. Your participation is greatly appreciated but not required.

J. HIV/AIDS/STD EDUCATION

HIV is a virus which never leaves the body once it has been contracted. Many viruses stay in the body for only a few days but once a person has tested positive for HIV, he/she will always be positive. HIV actually stands for Human Immunodeficiency Virus and over time it infects and kills white blood cells which help the body fight off certain types of infections and cancers, leaving the body highly susceptible to other illnesses.

Once HIV has progressed far enough that it effectively weakens the body and immune system, the carrier usually becomes ill from one of several infections, such as pneumonia or tuberculosis, that their body and immune system are no longer strong enough to fight. When the HIV virus has progressed this far it is called AIDS, which stands for Acquired Immune Deficiency Syndrome. The time it takes for HIV to progress into AIDS varies and may take up to 10 years or more.

As is often the case with many sexually transmitted diseases, it is often impossible to tell if someone else has HIV and many carriers do not know that they are infected. Initial symptoms are non-specific, often resembling symptoms of common cold or flu viruses, and may include:

- Fatigue
- Fever
- Rash
- Headache
- Swollen lymph nodes
- Sore throat

These symptoms are not a reliable way to diagnose HIV as they will only occur within days or weeks of the initial exposure. Testing for HIV antibodies is the only way to know whether you have been infected.

The HIV antibody test only works after the immune system of the infected person has been able to develop antibodies. The “window period” between the initial infection and when antibodies are detectable may be from 2 weeks to 6 months. The average “window period” lasts about 3 months and standard HIV testing during this time is ineffective. It is recommended that persons who test negative have additional testing in 6 months in order to rule out this “window period” and obtain an accurate result.

Persons who are engaging in at risk behaviors are more likely to contract HIV and other sexually transmitted diseases than persons who are not. If you or your sexual partner(s) have engaged in any of the following behaviors you are at risk and should be tested.

- Any type of unprotected sexual contact
- Sex with an IV drug user
- History of STDs such as herpes, Chlamydia, gonorrhea or hepatitis.
- Unplanned pregnancy
- Victim of sexual assault
- Passed out after drinking or getting high or been unable to remember what happened

- Shared needles or other equipment which pierces the skin

If you are interested in contacting confidential testing sites at which you and/or your significant other can receive testing for HIV/AIDS and other STDs as well as further education please contact your county Department of Human Services office. If you, your spouse, significant other, or other sexual partners would like to receive educational counseling sessions regarding HIV and other STDs then please notify your primary clinician.

Oklahoma HIV/AIDS Hotline - 1800-535-2437 (TDD Available)
National HIV/AIDS Hotline - 1800-243-7889 (TDD Available)
CDC (Centers for Disease Control) National HIV/STD Hotline - 1800-342-2437 (TDD Available)
Native American HIV/AIDS Hotline - 1800-238-2437
Spanish Language HIV/AIDS Hotline - 1800-344-7432 (TDD Available) STD
National Hotline - 1800-227-8922 (TTY Available)

Oklahoma State Medical Association: For access to Medical services including; testing, dental, medical case management and transportation – 1-405-843-9571

K. WELLNESS SERVICES AND SUPPORTS/CLIENT AND FAMILY HEALTH EDUCATION:

Stigler Health & Wellness Center, Inc. provides Client and Family Health Education. Client and Family Health Education will be conducted with patients and families during regular office visits by a multidisciplinary team including nurses, providers, behavioral health practitioners, and referral to specialist if needed. The purpose of this service is to ensure that the patient and their family are provided accurate and appropriate information and assistance regarding diagnosis, treatment, and related behaviors for achieving and maintaining a healthy standard of life. You may request family health education to your LBHP provider and he/she can refer you to the appropriate professional to assist you with this service.

L. DISCHARGE FROM OUTPATIENT BEHAVIORAL HEALTH TREATMENT

Typically, patients discharge from services when individual goals are met. A discharge criterion is discussed with the patient beginning at intake so that you and the treatment team can focus on problem resolution. When you attain the level of functioning determined in the treatment planning phase, procedures will begin to discharge the patient

On occasion, a discharge will occur for a reason other than completion of the treatment plan. In the event you are not offered certain services, you have the right to know why a particular service might be refused. Should you ever be refused treatment from HWC you will be provided with a written explanation concerning the reason you were refused certain services. You as a patient will not be subjected to any unnecessary, inappropriate, or unsafe termination from treatment. Discharge will not take place as punishment for displaying symptoms of a disorder.

This page is to be retained by HWC and placed in the PATIENT BEHAVIORAL HEALTH RECORD.

M. CONSENT FOR FOLLOW-UP

Upon termination of services from this program, we may want to contact you regarding your status and for you to answer some questions concerning satisfaction regarding services received. The purpose of this information is to assure the continuity of care and to provide HWC with pertinent statistical information. You may revoke permission for follow-up at any time by giving this agency a written notice or by refusing to participate in any follow-up by HWC Follow up will be the same with all persons served regardless of referral status.

CONSENT: I hereby ☐ **GIVE** ☐ **DO NOT GIVE** **(Please check one)**
permission to HWC to contact me by telephone or letter for follow-up and to answer questions concerning my satisfaction with services and my current status.

N. ACKNOWLEDGEMENT OF RECEIPT OF PATIENT HANDBOOK

Please initial to verify receipt of the following
_____Code of Ethics
_____Patient Rights
_____Confidentiality of Patient Records
_____HIPAA Notice Complaint/Grievance Procedure
_____Orientation Information
_____Patient Expectations
_____HIV/AIDS/STD Education Session
_____ Client and Family Health Education
_____HIV/AIDS/STD Referral Information

Do you or significant other wish to receive information: ☐ Yes ☐ No

HIV/AIDS/STD Education	HIV/AIDS/STD TESTING	Ct/Family Health Education
☐ Self	☐ Self	☐ Self
☐ Significant Other	☐ Significant Other	☐ Significant Other
☐ Both	☐ Both	☐ Both

Is patient under the age of 21? ☐ Yes ☐ No

If yes, does HWC therapist have permission to see him/her at school?
☐ Yes ☐ No ☐ NA

HWC has been providing quality healthcare services to our communities since 2005. As a Community Health Center, we offer services to those with private insurance, Medicare, Oklahoma Medicaid/SoonerCare, as well as the uninsured/under-insured, with fees based on household size and income.

The undersigned acknowledges that he/she has received a copy of the Patient Handbook which has been communicated to him/her in a meaningful way. Furthermore, he/she has read and understands this document in its entirety and further certifies that he/she agrees to the terms and provisions stated herein.

Patient Name:_____ Patient Number: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date