Telemedicine PACKET
Adult / Child

(To be explained to staff and signed by Individual, then FILED IN CHART – Individual will be given "Individual Orientation" at intake)

New PROGRESSIONS LLC

Individual Name: First MI Last	DOB:	Medicaid/Insurance#:	DOS:

(SB revised 11/18/2020)

SUMMARY OF INDIVIDUAL RIGHTS IN COMMUNITY MENTAL HEALTH, AND SUBSTANCE ABUSE

(Provide Client Copy)

When you receive services in a community mental health, mental retardation, and/or substance abuse program, your rights are protected by Rules and Regulations contained in Chapter 290-4-9. A full copy of the Rules is available to you at the program where you are served. Below is a simplified outline of those rights. The Rules and Regulations describe any limitation to these rights and other provisions, which may apply and should be consulted when there is a dispute or question regarding any of these rights.

Your rights include:

- The right to an interpreter if you do not speak English or are hearing impaired.
- The right to receive services that respect your dignity, and protect your health and safety
- The right to know the names and positions of all those involved in services planning and implementation process
- The rights to be informed of the benefits and risk of your treatment.
- The rights to participate in planning your own program.
- The right to refuse service, unless a physician or licensed psychologist feels that refusal would be unsafe for you or others.
- The right to receive care suited to your needs.
- The right to prompt and confidential services even if you are unable to pay.
- The right to review and obtain copies of your records, unless the physician or other authorized staff feels it is not in your best interest.
- The right to exercise all civil, political, personal and property rights to which you are entitled as citizen.
- The right to be free of physical or verbal abuse.
- The right to converse privately, to have reasonable access to a telephone, to receive/send mail, to have visitors and to retain your personal effects, clothing and money, except if denial is necessary for treatment/rehabilitation-documented by physician/licensed psychologist.
- The right to have advance directives, such as a living will, health care proxy, or durable power of attorney that clearly states your treatment wishes.
- The right to file a complaint if you think any of these rights have been restricted or denied.

If you want to know more about your rights, a full copy of the Regulations is available to you on report. A summary of the Individual Rights Complaint Process is also available.

The Individual/Legal Representative has had an opportunity to read, or have read to him/her, the above form and ask questions regarding the data contained therein and has in this staff member's presence.

Individual/Guardian Printed Name	Date
Individual/Guardian Signature	Date
NP Assessor/Witness Printed Name	Date
NP Assessor/Witness Signature	Date

SAFETY PLAN - CRISIS PREVENTION PLAN

Individual's Printed Name:_____ Date: _____

PROBLEM BEHAVIORS: These are behaviors I sometimes show, especially when I'm stressed:

- □ Losing my temper
- □ Fighting/Assaulting people
- □ Feeling suicidal
- □ Running away
- □ Using other drugs
- □ Injuring myself
- □ Attempting suicide
- □ Threatening others
- □ Using alcohol
- □ Feeling unsafe
- □ Other (please describe):

TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

- □ Not being listened to
- □ Feeling pressured
- □ Being touched
- □ Lack of privacy
- □ People yelling
- □ Loud noises
- □ Feeling lonely
- □ Arguments
- □ Not having control
- □ Being isolated
- □ Darkness
- □ Being stared at
- □ Being teased
- □ Particular time of day:
- □ Particular time of year:
- □ Contact with family
- □ Particular person:
- □ Other (please describe):

_____ _____

WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

- □ Sweating
- □ Breathing hard
- □ Racing heart
- □ Clenching teeth
- □ Clenching fists
- □ Red faced
- □ Wringing hands
- □ Loud voice
- □ Sleeping a lot
- □ Sleeping less
- □ Acting hyper
- □ Swearing
- □ Bouncing legs
- □ Rocking
- □ Can't sit still
- □ Being Rude
- □ Pacing
- □ Crying
- □ Squatting
- □ Damaging things
- □ Eating more
- □ Eating less
- □ Not taking care of myself
- □ Isolating/avoiding people
- □ Laughing loudly/giddy
- □ Singing inappropriately
- □ Becoming very quiet
- □ Other (please describe):

_____

INTERVENTIONS: These are things that might help me calm down and keep myself safe when I'm feeling upset:

(Check off what you know works; star things you might like to try in the future)

- □ Time out in my room
- □ Listening to music
- □ Reading a book
- □ Sitting with staff
- □ Pacing
- □ Talking with friends
- □ Talking with an adult
- □ Coloring
- □ Molding clay
- □ Humor
- □ Exercising
- □ A cold cloth on face
- □ Writing in a journal
- □ Punching a pillow
- □ Hugging a stuffed animal
- □ Taking a hot shower
- □ Taking a cold shower
- □ Playing cards
- □ Video Games
- □ Lying down
- □ Ripping paper
- □ Screaming into pillow
- □ Holding ice in my hand
- □ Getting a hug
- □ Using the gym
- □ Bouncing a ball
- □ Male staff support
- □ Female staff support
- □ Deep breathing
- □ Speaking w/ my therapist
- □ Drawing
- □ Being read a story
- □ Making a collage
- □ Crying
- □ Snapping bubble wrap
- □ Being around others
- □ Doing chores/jobs
- □ Cold water on hands
- □ Drinking hot herb tea
- □ Using a rocking chair
- □ Calling family (who?)
- □ Other (please describe):

THINGS THAT MAKE IT WORSE: These are things that do **NOT** help me calm down or stay safe:

- □ Being alone
- □ Being disrespected
- □ Being reminded of the rules
- □ Being around people
- □ Loud tone of voice
- □ Being touched
- □ Humor
- □ Being ignored
- □ **Other (please describe):** _____
- □ Not being listened to
- □ Having staff support
- □ Peers teasing
- □ Talking to an adult

CRISIS PLAN:	RESPONSE	SAFETY CONTACT
1). I will try to notice the following warning signs and triggers:		**Safety Plan Contacts and Resources (People I Can Ask for Help)**
2). I'd like staff/my family to notice the following warning signs:		**1). Name/Role** _____
3). When I notice these triggers or warning signs, I will take action to prevent a crisis from developing by doing the following:		Contact # _____
4). When staff/my family notice that I'm getting upset, I'd like them to help me prevent a crisis by doing the following:		**2). Name/Role** _____
5). When I handle a potential crisis without doing anything to make it worse, I can reward myself by:		Contact # _____
6). Other ideas about what to do if a crisis develops:		**3). Name/Role** _____
		Contact #
If Decompensation is evident, Please contract GA Crisis and Access line: 1 (800)715 4225 and/or 911 AND/OR GO TO NEAREST EMERGENCY ROOM		

Safety Plan (Guide)	**My Safety Plan (Guide)**
Things to notice:	Things to try: Distractions: play a videogame, do a crossword puzzle, call a friend on the phone, get some physical exercise (run around the block, play hoops, jump rope), hold on to an ice cube

Individual Name: First MI Last	**DOB:**	**Medicaid/Insurance#:**	**DOS:**

Triggers: Sudden loud noises, being teased, being told "no," being physically crowded, being reminded about the rules, dinnertime Warning signs: Getting really quiet, withdrawing, clenching my fists, heart pounding, thinking "it's not fair," getting a headache	Self-soothing: put on happy music, take a hot shower, play my guitar, have a cup of tea, say to myself "I can handle it," do deep breathing Don't try: telling me to "chill," giving me a hug, watching a sad movie

Individual's Printed Name: _____ Individual's Signature: _____ Date: _____

NP Staff/Witness Printed Name: _____ NP Staff Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

Individual Name_____ DOB: _____

I attest that I have voluntarily entered into treatment/requested services or given my consent for the minor/person under my legal guardianship mentioned above. I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor or intern in collaboration with his/her supervisor. I understand New Progressions, LLC is a Comprehensive Behavioral Health Program and does not offer Medication Management Services Only. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. New Progressions, LLC, Inc. ("NP") encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Non-Voluntary Discharge from Treatment: A client may be terminated from NP non-voluntarily, if:

A) The client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic.

B) The client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations or does not make payment in a timely manner.

The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinical Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by NP and/or State law and regulations. Generally, NP may not say to person outside NP that a client attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

1) the client consents in writing
2) the disclosure is allowed by a court order
3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at NP against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is NP's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

In signing this consent, I am stating that I understand and agree to the treatment I will receive and that the benefits and risks of this procedure have been explained to me. I understand that I may terminate or withdraw from this treatment an anytime.

I consent to treatment and agree to abide by the above.

Individual/Guardian Printed Name	Date
Individual/Guardian Signature	Date
NP Assessor/Witness Printed Name	Date

Individual Name: First MI Last	DOB:	Medicaid/Insurance#:	DOS:

NP Assessor/Witness Signature Date

ADVANCE DIRECTIVES INFORMATION

The Patient Self-Determination Act
As of December 1, 1991 the provisions of the Patient Self-Determination Act became effective. This act requires that certain health care facilities participating in the Medicare or Medicaid programs provide Individuals with information regarding their rights under state law to make decisions regarding medical care. This includes the right to refuse treatment and to execute living wills, powers of attorney, and other advance directives addressing the provision of medical care and psychiatric care. Care will not be denied because an individual does not have an advance directive.

Psychiatric Advanced Directive
Psychiatric Advance Directives is a document that outlines the psychiatric care you would like to receive in the event you become unable to make the decision for yourself or an individual you have guardianship over. Anyone with a severe and persistent mental illness should consider obtaining one. However, at the present time a psychiatric advance directive is not a legal document in the State of Georgia. There is a bill before the State legislature to make them a legal document.

Advance Directive
An advance directive is a written document, such as a living will or durable power of attorney for health care that makes your wishes clear regarding your medical and psychiatric care if you become unable to communicate your decisions to your care provider.

Living Will
A living will is a written directive that lets you state what type of medical treatment you do or do not wish to receive if you are too ill or injured to direct your own care, up to and including withholding or withdrawing life saving and/or sustaining procedures. State law describes a specific kind of form that must be used in order for a living will to be valid.
This form must be signed, dated, and witnessed.

Durable Power of Attorney for Health Care
A durable power of attorney, also known as a medical power of attorney, is a signed, dated, and witnessed **legal** document in which you designate a trusted person (an agent or attorney-in-fact) to make medical decisions for you if you become unable to make the decisions yourself. You can give your agent the authority to oversee the wishes you've set out in your health care declaration, as well as the power to make other necessary decisions about health care matters.

_____ I currently have the following, and am providing New Progressions staff with a copy:
- ☐ Advanced Directives for Medical Crisis
- ☐ Advanced Directives for Psychiatric Crisis

_____ I do not have any Advanced Directives

If you are interested in obtaining an Advanced Directive you may contact:
The Georgia Mental Health Individual Network
1-800-297-6146
www.gmhcn.org
National Mental Health Association (NAMI)
1-800-969-6642
www.nmha.org/position/advanceddirectives.cfm
You may go to Brazelon Center for Mental Health Law
202-467-5730
www.bazelon.org/publications/advanceddirectives
New Progressions staff may not assist in the writing or witnessing of a Psychiatric Advance Directive

_____	_____
Individual/Guardian Printed Name	Date
_____	_____
Individual/Guardian Signature	Date
_____	_____
NP Assessor/Witness Printed Name	Date
_____	_____
NP Assessor/Witness Signature	Date

COVID-19 LIABILITY WAIVER

COVID-19 has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state and local governments, and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

New Progressions, LLC has put in place preventative measures to reduce the spread of COVID-19; however, New Progressions, LLC cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments with New Progressions, LLC could **increase** your risk and your child(ren's) risk of contacting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself, my family and or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments with New Progressions and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at New Progressions, LLC may result from the actions, omissions, or negligence of myself and others, including, but not limited to New Progressions, LLC their employees, contractors, volunteers, interns and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability or expense of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments with New Progressions, LLC its employees, contractors, agents, interns, volunteers and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that the release includes any claims based on the actions, omissions, or negligence of New Progressions, LLC its employees, agents, staff, contractors, and representatives, whether a COVID-19 infection occurs before, during , or after participation in any in-person appointments with New Progressions, LLC.

_____ _____

Printed Name of Participant Participant Signature & Date

COVID-19 HOTLINE: 646-697-4000

For Office Use Only: Referred To:_____ ☐ **Incident Report Completed** ☐ **Staff Initials** _____

☐ Comments:_____ _____

Individual Name: First MI Last	**DOB:**	**Medicaid/Insurance#:**	**DOS:**

Individual Name: First MI Last	DOB:	Medicaid/Insurance#:	DOS:

AUTHORIZATION TO REQUEST/RELEASE INFORMATION

Client Name: _____ DOB: _____ Gender: _____
Parent/Guardian Name: _____ Contact Number: _____
Social Security Number: _____ Insurance Provider: _____
Email Address: _____

I give consent ❑ To Obtain Records Request from and/or ❑ To release records to:

Request From Date:_____ To Date:_____
Agency Name: _____
Address: _____ City: _____State: _____ Zip: _____
Phone: _____Fax Number:_____Email Address: _____

- ❑ **Assessments**
- ❑ **Psychosocial Evaluation**
- ❑ **Psychological Evaluation**
- ❑ **Psychiatric Evaluation**
- ❑ **Treatment Plan or Summary**
- ❑ **Current Treatment Update**
- ❑ **Medication Management Information and/or information regarding compliance or participation in treatment**
- ❑ **Toxicological Reports/Drug Screens**
- ❑ **Medical/Nursing Exams/Assessments**
- ❑ **Progress in Treatment**
- ❑ **Demographic Information**
- ❑ **Continuing Care Plan**
- ❑ **Discharge/Transfer Summary**
- ❑ **Other _____**
- ❑ **Other _____**

Purpose:
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation:
I understand that I have a right to revoke this authorization, in writing, at any time by sending **written notification to New Progressions, LLC at 5526 Old National Hwy Ste B Atlanta Georgia 30349.** I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires **ONE YEAR FROM THE DATE OF SIGNATURE.**

Conditions
I further understand that New Progressions, LLC LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: If services (ie. psychiatric, confirmed diagnosis, substance abuse treatment, and therapy) are hindered, prevent clinician from properly advocating or acting in the client's best interest, or create a danger due to clients refusal to sign authorization then New Progressions, LLC may choose not to continue services to client.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: **medical or life threatening emergency**

Signature of Individual Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Initial here if patient/client refuses to sign authorization

Signature of Staff/Title Witnessing

Individual Name: First MI Last	DOB:	Medicaid/Insurance#:	DOS:

TELEMEDICINE MEMBER CONSENT FORM

PATIENT NAME: _____
DATE OF BIRTH:_____ INSURANCE ID#:
_____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s): *Medication Management, send and receive documents electronically, counseling, skills training and all CORE services to maintain my mental health.*

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
    a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place.
    c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
    d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultation for the procedure(s) described above.

Signature:_____Date: _____

If signed by someone other than the patient, indicate relationship:_____

_____

Witness Signature:_____Date: _____

Individual Name: First MI Last	DOB:	Medicaid/Insurance#:	DOS:

Counselor/Clinician Name

Parent/Guardian Name (s)

Staff Responsible for the Coordination/Integration of this plan

Client Signature **Signature Date**

Parent Signature **Signature Date**

Clinician/Case Worker Signature **Signature Date**

Licensed Clinician Signature **Signature Date**

Psychiatrist Signature **Signature Date**

Psychiatric NP Signature **Signature Date**