# CREATIVE SPIRITS BEHAVIORAL HEALTH, INC.

Community Behavioral Health 12730 Townepark Way, Suite 201, Louisville, KY 40243
**T** (502) 254-9555 **F** (502) 254-9554

## NEW PATIENT ENROLLMENT

*Please read and complete each of the documents listed below as complete as possible. This will take approximately forty minutes. These documents are intended to be resources for you, as well as helpful aides to us for your care and treatment.*

Enclosed are the following documents for you to carefully review and complete:

- New Patient Registration
- Health Insurance Information
    - In order for any claims to be submitted to your health insurance company this document **must** be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).
- Assignment of Benefits
    - Assignment of benefits is not required for treatment. However, it **is** required if you would like us to bill your insurance company for you.
- Payment Authorization Form
- Authorization to Release of Information for Treatment, Billing of Healthcare Operations
    - Authorization is **not** required for treatment. However, it may be required for sending your insurance company additional information requested for claims processing.
- Authorization to Release, Exchange, or Obtain Information
- Parental Authorization for Confidentiality
    - This form is for parents with minors to complete.
- Authorization for Emergency Medical Treatment
    - This form is for parents with minors to complete.
- Consent for Care
- Treatment Contract
- Freedom of Choice
- Client Rights
- Client Rules and Regulations
- Group Rules
- Electronic Media/Social Media Policy
- Combined Acknowledgement of Receipt of Notice of Privacy Practices and Policies and Acknowledgement of Receipt of Notices of Office Policies and Procedures

You may keep the *Notice of Privacy Practices and Policies, Notice of Office Policies and Procedures, and Statement of Privacy Practices* for your reference. Please bring all other completed forms to your first appointment. Please feel free to request copies of any other forms.

Billing and patient accounts are administered by Creative Spirits Behavioral Health, Inc. in Louisville, KY by Account Manager, Detroyia McGruder. She may be contacted by telephone at (502) 254-9555 or email at billing@creativespiritsonline.com.

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**NEW PATIENT REGISTRATION** **Date:**

## GENERAL INFORMATION

Name: _____ DOB: _____ Sex: _____

Marital Status: Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed ☐

Mailing Address: _____
Street City State ZIP

SSN: _____ Employer: _____

Home Telephone: _____ May we leave a message? Yes ☐ No ☐

Work Telephone: _____ May we leave a message? Yes ☐ No ☐

Cellular Telephone: _____ May we leave a message? Yes ☐ No ☐

Work E-mail: _____ May we send a message? Yes ☐ No ☐

Home E-mail: _____ May we send a message? Yes ☐ No ☐

## MEDICAL AND REFERRAL INFORMATION

Complete Name of Primary Care Provider: _____

Primary Care Provider's Telephone Number: _____

Complete Name of Referring Physician: _____

Referring Physician's Telephone Number: _____

Who referred you to our practice? _____

How did you hear about our services? _____

Have you had prior counseling? Yes ☐ No ☐ If yes, briefly describe how it was helpful:

_____

## EMERGENCY CONTACT

You are giving consent to Creative Spirits to contact this person during any emergency as defined by Creative Spirits Behavioral Health. Yes ☐ No ☐

Who should we contact in case of an emergency? _____

Relationship to you: _____

Home Telephone: _____ Work Telephone: _____

Cellular Telephone: _____ Other: _____

**OFFICE USE ONLY**: ☐Service Coordinator ☐BH Professional ☐Therapeutic Child Support ☐Psychiatrist ☐Child Care ☐PCP
Name & Phone: _____

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## HEALTH INSURANCE INFORMATION

*In order for any claims to be submitted to your health insurance company the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).*

*:*

### PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____

Insurance Company Telephone Number: _____

Insurance Company Address: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐Other:_____

Patient ID: _____ Patient Birthdate: _____

Patient Insurance Group #: _____ Patient SSN: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscribe Birthdate: _____

Subscriber Insurance Group #: _____ Subscribe SSN: _____

Subscriber Address: _____

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*

### SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐Other:_____

Patient ID: _____ Patient Birthdate: _____

Patient Insurance Group #: _____ Patient SSN: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscribe Birthdate: _____

Subscriber Insurance Group #: _____ Subscribe SSN: _____

Subscriber Address: _____

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*

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## ASSIGNMENT OF BENEFITS

I hereby assign to Creative Spirits Behavioral Health, Inc. my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid, in my name or on my behalf. I further authorize payment of benefits directly to Creative Spirits Behavioral Health, Inc. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-injured health plan, or government plan covering services provided by Creative Spirits Behavioral Health, Inc.

*With the exception of Medicaid patients*, I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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## PAYMENT AUTHORIZATION FORM(S)

At Creative Spirits Behavioral Health, Inc., we highly recommend keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent (%) of the total bill will be charged for each month that the bill remains unpaid. *(All publicly funded sources are not liable, including Medicare and/or Medicaid patients)*

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

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I authorize Creative Spirits Behavioral Health, Inc. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Credit Card #: _____

Expiration Date _____

Cardholder Name _____

Signature _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

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I (we), the undersigned, authorize and request Creative Spirits Behavioral Health, Inc. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Creative Spirits Behavioral Health, Inc.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Creative Spirits Behavioral Health, Inc. in writing and the account must be in good standing.

PATIENT NAME (PRINT) _____

SIGNATURE _____ DATE _____

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## AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

*You are not required to give this authorization, however, claim charges denied due to a failure to provide requested documents (due to lack of authorization) will be the responsibility of the patient.*

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that Creative Spirits Behavioral Health reserves the right to change their notices and practices, and that I will be notified if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that Creative Spirits Behavioral Health and support staff have already taken action in reliance thereon. I also understand that Creative Spirits Behavioral Health and his/her support staff are not requiring to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

Records may be needed in order to process a claim for clinical services. I authorize Creative Spirits Behavioral Health to release information needed for billing purposes to entities that may provide services pertaining to my therapist visit, such as reference laboratories. I understand that signing below, I am authorizing the release of all or part of my clinical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.*

*The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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## AUTHORIZATION TO RELEASE, EXCHANGE, OR OBTAIN INFORMATION

### PATIENT INFORMATION

Full Name: _____ DOB: _____
Address: _____
City, State, ZIP: _____ Phone Number: _____

### INFORMATION TO BE RELEASED

I hereby authorize Creative Spirits Behavioral Health, Inc. to (please initial all that apply)
_____ Release Information to _____ Gather Information from ____ Exchange Information with

### RELEASED TO

Full Name: _____ Agency Name: _____
Address: _____
City, State, ZIP: _____ Phone Number: _____

This information may consist of the following (please initial each line to which consent is given):
_____ Psychological test reports
_____ Psychiatric evaluation reports
_____ Periodic reports of psychotherapy, program attendance and/or prognosis
_____ Social History Data (family, education, employment, arrest, drugs, and alcohol)
_____ Medical and/or Mental Health Information
_____ Other (specify): _____

This information will used (please initial each line to which consent is given):
_____ To determine appropriateness of treatment
_____ To develop a diagnosis and treatment plan
_____ To facilitate coordination of services
_____ Legal/School purposes
_____ At the request of the individual
_____ Other (specify): _____

### ACKNOWLEDGEMENT

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be redisclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked after the termination of patient care and receipt of payment for all services.

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services at Creative Spirits Behavioral Health, Inc.

_____ _____
Client Date Staff Signature Date

**Prohibition of Redisclosure:**

This release does not authorize disclosure by its recipients. If the record contains drug or alcohol information, it may be protected by Federal Confidentiality Rules (42CFR Part2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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## PARENTAL AUTHORIZATION FOR CONFIDENTIALITY

**PATIENT INFORMATION**

First Name: _____ DOB: _____
Address: _____
City, State, ZIP: _____ Phone Number: _____

I understand that my adolescent is participating in

| | | | |
|---|---|---|---|
| _____ | Drug/Alcohol Substance Abuse | _____ | Anger Assessment |
| _____ | Drug/Alcohol Education Group | _____ | Anger Management Group |
| _____ | Adolescent Outpatient Group | _____ | Random Drug/Alcohol Screening |
| _____ | Relapse Prevention Group | _____ | Individual Counseling |
| _____ | Teen Support Group | | |
| _____ | Other (specify): _____ | | |

at Creative Spirits Behavioral Health, Inc., and that this is done with my full knowledge and approval. I further understand and agree that, in the interest of effectiveness of the services provided, the content of this participation shall be considered confidential and will not be divulged to me unless otherwise agreed by adolescent with the exception of a positive drug/alcohol screen result, I am also aware that while participating in services provided at Creative Spirits Behavioral Health, Inc., my adolescent will be subject to random drug/alcohol screens.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
## (ONLY NECESSARY FOR CLIENTS WHO ARE MINORS)

I, client (or the legal guardian or parent of the following child):
Client Name: _____ DOB: _____ Sex:_____

give consent for Creative Spirits staff/contractors to seek out and sign for the emergency medical care of my child or legal ward.

Parent or Legal Guardian Name & Address: _____

Daytime Telephone: _____Evening Telephone: _____

Emergency Telephone: _____

I give consent for the following person to be contacted in the event of an emergency:

Emergency Contact Person _____Relationship to client: _____

Address: _____

Emergency Telephone: _____

I understand that reasonable effort will be made to contact the guardian at the above phone numbers. If the child is considered to be in immediate danger and requiring medical care, I give consent for emergency medical care. I do not hold Creative Spirits Behavioral Health, Inc. or its representatives liable for any injury or expense incurred in providing and securing medical care.

**Health Information**

Allergies: _____
_____

Is Client on Medications?: _____
_____

Medical Problems: _____
_____

Physicians Name & Phone: _____

Hospital Preference: _____

Does client have private health insurance? _____If yes, please provide the following:

Primary Insurance Company: _____

Patient ID: _____ Patient Birthdate: _____

_____ _____
**Client** **Date** **Staff Signature** **Date**

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## CONSENT FOR CARE

I, the patient or patient's legal representative, hereby grant permission to Creative Spirits Behavioral Health, Inc. to perform such psychological evaluations, assessments, treatments, and therapeutic procedures such as collateral therapy and case management services as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment and healthcare operations.

I am aware that the practice of mental health is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

I understand that I will be treated with consideration, respect, and personal dignity. I also understand that Creative Spirits Behavioral Health, Inc. will make appropriate referrals for me if I have needs that they are unable to address.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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## TREATMENT CONTRACT

I understand that Creative Spirits Behavioral Health, Inc. practices under guidelines set forth by Kentucky and their professional associations. I understand that I will have access and shall review my client record and may request for my records by submitting a written request to the clinical director.

I agree to attend the required number of sessions as indicated on the treatment plan and understand that an absence does not count for a session.

I agree to positively participate in group sessions and understand that failure to do so may result in my case being returned to court/referring agency as non-compliant.

An active Release of Information will be signed to allow Creative Spirits to contact the court/referring agency, probation and parole, family members, and all other parties deemed necessary by the counselor. I understand that this release allows for Creative Spirits to obtain/release information in accordance with the administrative regulations.

I understand that my completion of the program is contingent on participation, completion of treatment goals, attending the required number of psycho-educational sessions, and payment of services in full. Failure to meet any of these requirements or **exceeding two or more unexcused absences** will result in a *non-compliant discharge*. Hospitalization, births, and deaths of immediately family and a documented illness are the only excused absences. Upon accumulation of absences, I will be removed from the program, my record will be terminated, and a letter will be forwarded to the court. If I voluntarily drop out and the court/referring agency requires Creative Spirits to reinstate me, I understand that I must start over and that I am responsible for payments of the previous session that I attended.

I understand that Creative Spirits will notify the referral agent upon successful completion and/or termination from the program. Termination prior to successful completion and full payment may have negative consequences including but not limited to incarceration.

I understand that I have a right to refuse services from the program and understand that the referral source will be notified within five days of my refusal.

I agree to pay for any individual session that I schedule.

I understand that I must attend my assigned group only. I agree to follow the sign-in procedures for group so that my attendance can be accurately recorded. I understand that I must contact the main office to seek approval to attend a group other than the one that I have been assigned. Failure to provide prior notification of group change may result in my attendance not being properly recorded which could lead to my discharge from the program.

I understand that I must contact Creative Spirits prior to missing any sessions or it will be considered an unexcused absence.

I understand that I must treat the staff and other participants in the program with respect and dignity. I understand that rude, disruptive or other inappropriate behavior will not be tolerated and may result in my dismissal from the group session or termination from the program. I will refrain from bringing any firearms or other weapons to the session.

I understand that I will not attempt to harm myself or anyone else in any way. I also agree that I will inform a member of the staff immediately if I think about or feel that I or someone else will harm others or myself.

I agree to sign a confidentiality statement and will respect the confidentiality of other group members.

**Outpatient Substance Abuse Only**

I understand the rules of client conduct, including the consequences for the use of alcohol and other drugs, or other infractions that may result in disciplinary action or discharge.

I understand that certain statistical information concerning my case required by the Division of Substance Abuse and the court/referring agency is released to them by Creative Spirits.

I understand that I may be required to attend Alcohol Anonymous (AA), Narcotics Anonymous (NA), or other support groups as needed.

**Initial _____**

**Anger Management/Domestic Violence Offender Only**

I agree to refrain from new threats of abuse, acts of domestic violence and unlawful contact with the victim. I understand that I must report any violations of these conditions to the counselor for appropriate action. I understand that the program will report all instances of abuse, threats of abuse and any new acts of domestic violence to the proper authorities. If I am charged with a new domestic violence offense, I may be terminated from the program pending disposition.

I understand that I must take full responsibility for my violent behavior. I agree to accept responsibility for learning new skills to eliminate any verbal, emotional, sexual or physical abuse on my part.

I understand that I will be discharged within 24 hours if I violate a provision of the court order, perpetrate domestic violence or any other behaviors that are associated with increased risk of harm to the victim.

I understand the rules of client conduct, including the consequences for the use of alcohol and other drugs, or other infractions that may result in disciplinary action or discharge. I understand that I will not be allowed to attend, and may be terminated from the program, if I come to the session high or under the influence of alcohol or drug. I may also be required as a condition of re-entry to undergo a substance abuse assessment and follow the recommendations of the assessor.

I understand that certain statistical information concerning my case required by the Sexual and Domestic Violence Program Administrator and the court/referring agency is released to them by Creative Spirits.

**Initial _____**

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

**Staff Signature: _____ Date: _____**

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## FREEDOM OF CHOICE

I understand that the choice of providers is my responsibility and my right as the citizen and/or as a parent/guardian. I further understand that I have the right to contact any providers prior to selection so that I may determine the best provider for myself and/or for my child. I also understand that I may at any time choose another provider for this service by notifying my current provider.

I have reviewed the list of providers of _____ and choose the

following provider: _____.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

My TREATMENT TEAM and I have determined that the following service(s) is/are needed:

| | | |
|---|---|---|
| ☐ DUI Assessment | ☐ DVO Assessment | ☐ Substance Abuse Assessment |
| ☐ Psychiatric Evaluation | ☐ Intensive Outpatient Program | ☐ Supported Employment |
| ☐ Individual Therapy | ☐ Group Therapy | ☐ Collateral Therapy |
| ☐ Peer Support Services | ☐ Community Support | ☐ Behavioral Health Evaluation |

☐ Other: _____

I have reviewed the list of providers for the service(s) and choose the following provider(s):

_____ _____
_____ _____
_____ _____
_____ _____

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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## CLIENT RIGHTS

Creative Spirits clients have the right to be treated with respect for their dignity, individuality, and humanity. Creative Spirits clients have the right to confidentiality in their treatment and in their personal lives. They also have the right to personal privacy regarding their individual treatment plan. Creative Spirits clients have a right to informed consent; this includes the right to be informed of available program services, procedures and treatment that they shall receive. Creative Spirits clients have the right to be fully informed of their rights and of the expectations of treatment. Creative Spirits Behavioral Health, Inc. does not discriminate on the basis of race, ethnic group, religion, gender, sexual orientation, political ideation, ability, educational level or previous life condition. Creative Spirits has the right to contribute to the goals, objectives, and interventions of your service plan. You have the right to complain and to expect resolution. Each client is encouraged to exercise his/her rights as a client and a citizen and to this end may voice any grievances. Creative Spirits clients have the right to refuse to continue services at any time. Creative Spirits clients have the right to confidentiality. Information about your treatment or services with Creative Spirits can be released to you or others only with your written consent. Exceptions to this law apply when the client or family member is in danger of causing injury to self or someone else. In limited circumstances the courts can force a therapist or service provider to release records to the legal system.

**PROCEDURES IF CLIENT RIGHTS HAVE BEEN DISREGARDED**

If you have questions, would like additional information, or feel your client rights have been violated, you may contact the Privacy Officer.

**Responsibilities**

As a client or client guardian, you have the responsibility to provide accurate and completed information and to report any changes in the child's well being. You have the responsibility to keep all appointments to the best of your ability and to give 24 hours notice to the provider if you are unable to keep an appointment. You are responsible to maintain the child's medical card and to report any lapse in coverage to the service provider. You are responsible to contribute to the formulation of a service plan with its goals and objectives and to follow through with your agreed upon interventions.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

**Staff Signature: _____ Date: _____**

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## CLIENT RULES AND REGULATIONS

- Absolutely no attending class while under the influence of mood altering chemicals.
- Smoking is not allowed on the premises of Creative Spirits.
- If you are fifteen (15) minutes late for a session, you may stay; however, your attendance will not be recorded.
- You are allowed a beverage during class; however, you may not bring food into the class.
- It is okay to disagree without being disagreeable.
- Participation in group discussion and/or assignments is required.
- You must be respectful and courteous to all program participants and group leader.
- Clients will attempt to attend all scheduled meetings and, if unable to attend, will contact the main office twenty-four (24) hours prior to appointment time.
- If you cannot attend class, you must call your group leader and attempt to talk directly to him/her or leave a message as to why you will not be attending.
- Payments must be made prior to attending your session or according to any personalized prearranged fee policy.
- All clients will receive information on all applicable confidentiality regulations.
- A treatment plan describing that plan's length, type and goals will be developed and signed by the counselor and client no later than the fourth ($4^{th}$) session.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

**Therapist Signature: _____Date: _____**

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## GROUP RULES

**(ONLY NECESSARY FOR DUI/DVO/IOP/SA CLIENTS)**

The basic rules for problem solving group therapy:

1. **Attendance and Punctuality:** Group members are responsible to attend all group sessions and to arrive on time and stay for the full group session.
2. **Compliance with Basic Responsibilities:** Membership in the group implies a willingness to comply with seven (7) basic group responsibilities described above.
3. **Freedom of Participation:** Within the constraints of the standard format and basic responsibilities, you can say anything you want anytime you want to say it. Other group members have the right to give you feedback and what you say and how you say it. Silence is not a virtue in this group and can be anti-therapeutic.
4. **Right of Refusal:** With the exception of refusing to comply with basic group responsibilities, you can refuse to answer any questions or complete any assignments. The group members cannot force you to participate, but they do have the right to express how they feel about your silence or your choice not to get involved.
5. **Confidentiality:** What happens in the group stays among the members with the exception of the group leaders who may consult with other members of treatment team in order to provide more effective treatment and may report any inappropriate behavior or violation of rules and responsibilities to the appropriate authority. Group members agree not to discuss the content of the problems presented by the other group members with anyone else.
6. **No Violence:** Acting out with physical or verbal violence within the group may be grounds for dismissal. Physical violence includes pushing, shoving, or hitting other group members. Verbal violence involves making threats, yelling, using profane language, and name calling. The threat of violence is as good as the act.
7. **No Dating, Romantic, or Sexual Involvement:** Dating, romantic involvement, or sexual involvement, among the members of the group is not allowed. Such activities can sabotage one or both person's treatment. If such involvement begins to develop, it is to be brought to the attention of the group or your individual counselor at once.
8. **Communication Prior to Termination:** Anyone who decides to leave group has responsibility to inform the group in person prior to termination.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

**Therapist Signature: _____Date: _____**

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Community Behavioral Health 12730 Townepark Way, Suite 201, Louisville, KY 40243
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## ELECTRONIC MEDIA/SOCIAL MEDIA POLICY

E-mail – Electronic mail should be used only for administrative communication, such as checking/arranging appointments or the communication of basic information. It should not be used to communicate therapeutic/highly personal information. E-mail is stored on servers even after it is opened, and e-mail sent through, as employer's e-mail account is the property of the employer, so privacy is not guaranteed.

Social Media – Our clinicians cannot be "friends" with any client on Facebook or other social media outlets. Because information on my Facebook page can be seen by all of my "friends," privacy of clients is compromised. Likewise, I cannot follow clients on Twitter or other social media outlets.

Texting – Text messages should be used only for administrative purposes, such as scheduling/changing appointments. My text messages are password protected.

All client data that is stored on my computer is encrypted. Text and e-mail messages are additionally protected by passwords.

Please check below if you would like to be able to communicate with me via e-mail or text message following the guidelines outlined above.

_____ I would like to communicate via the e-mail address: _____

_____ I would like to communicate via text to the following number: _____

I understand that I am responsible to communicate any changes in the above information.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

# CREATIVE SPIRITS BEHAVIORAL HEALTH, INC.

Community Behavioral Health 12730 Townepark Way, Suite 201, Louisville, KY 40243
**T** (502) 254-9555 **F** (502) 254-9554

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & POLICIES, OFFICE POLICIES & PROCEDURES, AND AGREEMENT BROCHURE

_____ initial

I have received a copy of the Notice of Privacy Practices and Policies: In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

_____ initial

I have received a copy of Creative Spirits Behavioral Health, Inc., Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to the Fees and Payments and Grievance Procedures. I also agree to abide by the late cancellation and missed appointment policy.

_____ initial

I have read, understand and agree to the following Agreements: Financial Agreement, Cancellation / Late / No-Show, 3rd-Party Payer Release and Assignment, Payment Authorization, Contract and Consent, Limits of Confidentiality, Privacy Policy, Release of Information, Court / Litigation, Acceptance of Agreement, Question or Problems – as well as the Emergency Contact provision.

**Patient Signature: _____ Date: _____**

**Patient Printed Name: _____**

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

FOR INTERNAL USE ONLY
If you were unable to obtain an Acknowledgement of Receipt or unable to obtain a signature for the Acknowledgement of Receipt, please state the reason below. Please include your name.