CONSUMER ORIENTATION CHECKLIST
Sassin and Associates
2215 E. 21st St
Tulsa, OK 74114

The following information has been provided as part of the consumer orientation. A check of the item indicates that it has been fully explained and is understood by the consumer.

- ❑ Agency Mission
- ❑ Acceptance of Community Based/In-Home Services
- ❑ Consumer Rights and Responsibilities
  - *Notification of Agency procedures/Non Compliance Consequences
- ❑ Grievance and Appeal Procedures
- ❑ Client input regarding services
  - *Assessment
  - *Treatment Planning
  - *Client Education
- ❑ Explanation of Services
  - *Programs
  - *Hours of Operation
  - *Access after Hours
  - *Code of Ethics
  - *Confidentiality Policy
  - *Follow-Up Requirements
- ❑ Fees/Financial Responsibilities
- ❑ Facility Orientation *Fire Plan
- ❑ Education regarding Advance Directives
- ❑ Explanation of Treatment Advocate
- ❑ Electronic Signature Agreement
- ❑ Procedures on Request for Records
- ❑ Identification of the person responsible for service coordination (Treatment Team)
- ❑ Program rules, including restrictions and the loss and regaining of rights and
- ❑ Discharge/transition criteria and procedures

Client Signature_________________________ Date: ________________

Parent/Guardian:_________________________ Date:________________

Provider_______________________________ Date: _______________

Sassin and Associates
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Program Description:

Sassin and Associates outpatient program provides a wide range of services to children starting at age 4, adolescent, adults, families and seniors.

Sassin and Associates mission: We at Sassin & Associates promote and encourage the empowerment of people with significant challenges so that each may pursue their highest possible degree of personal well-being and independence. All treatment is client centered, family focused, strength-based and culturally competent.

Core Services includes:

1. Psychotherapy: Outpatient therapist provides screening, intake, assessment, education and referral services as well as individual, family, and group therapy to consumers admitted into the Sassin & Associates program. Services are provided in the home, school and community.

2. Community-Based Services: Outpatient therapists and Certified Case Manager I & II provide, recovery focused behavioral health rehabilitation services to adults. Children and adolescent behavioral health rehabilitation services are focused on school, education and social functioning. These services are focused on consumers who are unable to function due to behavioral health and/or substance abuse issues with the goal to educate and increase the skills necessary to perform activities of daily living and function in the community.

3. Advocacy: Outpatient case managers advocate for families in order to help them overcome or confront barriers to better education, housing, health or other social/human needs. In order to increase access to care.

4. Crisis Intervention: Outpatient therapist provide emergency services 24 hours per day/7days per week. Evaluations will be performed to assist and intervene with individuals who are a threat to themselves and/or others.

5. Wellness and Support: Outpatient therapist provide behavioral health education, community outreach, wellness workshops, and support services to children, adolescent, families, faith based organizations and schools.

Program Eligibility

Services are available to consumer's age 4 years and older. Consumers will be admitted for treatment following an in person screening and intake. Consumers are eligible regardless of race, sex, religion, sexual orientation, disabilities or ethnic origin. Referral services will be provided to consumers to meet their immediate needs.

Accessing Service

Requests for services can be made by parents, school personnel, physicians, as well as adolescents. Families are scheduled for an initial evaluation which is followed by treatment. These services can be accessed Monday - Friday 8 a.m. to 5 p.m. by calling 918-949-4430 or faxing a referral to 918-949-4431. To reach a therapist after hours of normal operation call 918-949-7075

Client Fee
Fee for services are based on a sliding scale, although no services are denied because of inability to pay. Call your insurance company to confirm insurance coverage.

Client:_______________________________________ Date:________________________

Parent/Guardian:_____________________________ Date:______________________

Provider/Therapist:___________________________ Date:______________________

PRESCRIPTION DRUGS

Employees will keep prescription and over the counter medication secure from clients and other employees and will make the Executive Director/Director/Program Director aware of any possible side effects from a medical condition and the medications taken.

Illicit Drugs

In the event illicit drugs are discovered, the police will be contacted. The authorities are responsible for the disposal of or control of illicit at that point.

Weapons

Weapons of any kind are not allowed on the premises. In the event weapons are discovered, the police are contacted. The authorities are responsible for the acquisitions are control of the weapons discovered.

Exception: In the event the police are contacted for an emergency situation, they may deem it necessary to maintain possession of their authorized weapons for the safety and well-being of others.

Tobacco Use: Sassin and Associates prohibit smoking and/or use of any tobacco product in the facility. The entire building has a non-smoking policy. Staff and/or clients who use tobacco must do south side of the building. There are designated smoking areas outside of the building. At this time the designated locations are outside the front door facing north and the back door facing south.
Smoking will not be permitted in the vehicles owned or operated by the organization or by personnel transporting clients.

Destruction of property: the consumer is restricted from causing any destruction to property of CenterPoint or property in the community thereof.

Harm to self or others: the consumer may not cause or provoke harm to self or others.

Physical or verbal aggression: the consumer is restricted from provoking threats of physical or verbal aggression upon anyone at Sassin and Associates.

Sassin and Associates reserves the right to terminate services due to the following events, behaviors or attitudes:

- The possession of illegal drugs on the person of consumer served upon premises of Sassin and Associates
- Aggressive behavior directed toward staff or other consumers served
- Inappropriate sexual abuse, harassment or other behavior of the consumer served against staff or other consumers
- Hostile or biased attitude that includes but is not limited to derogatory, racial, cultural, gender related descriptions directed towards other consumers and or staff.
- A consumer may also lose temporary rights if he/she arrives at Sassin and Associates under the influence of any mood altering substance not prescribed by a doctor.
- Reinstatement of are at the discretion of the clinical director and will be made on a case by case basis. Client will be informed of decision to reinstate rights by mail.

Signature of Client 14 and older___________________ Date: _______________________________
Parent/Guardian__________________________ Date: _____________________________________
Therapist: ____________________________ Date:______________________________________

Sassin and Associates
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Consumer/Parent/Caregiver Acceptance Form
For Counseling Services

I ______________________, agree to accept counseling services from Sassin and Associates.

By signing this agreement, I understand that:

• Counseling services could take place in my home, office, school or in a private community setting, depending on the needs of my child/myself or my child. Name of Client: ________________________________.

• I will be an active part of the treatment process, and I am thereby expected to work cooperatively with the assigned therapist and case manager.

• I have received copies of the human rights guidelines, confidentiality limitations and grievance procedure, emergency procedures, and other relevant documents.

• I have received and I have been educated on Office Hours, phone numbers and crisis after hour procedures.
For after-hours mental health emergencies, consumer will call 911, Copes 918-744-4800 or
Crisis Line 918-260-7898 to reach an on call therapist immediately. For afterhours appointments, I can call 918-949-7075 to reach a therapist.

• Per mutual agreement, I and my/my child's therapist agree that counseling services may take place in the office, home, and community or in the school setting. Scheduling and goals of such sessions will be predetermined by counselor and myself during treatment planning.

• There are other mental health agencies that provide In-Home Services, and I have chosen Sassin and Associates as my service provider.

Parent Signature(s)

X______________________________ Date: _________________

X______________________________ Date: _________________

Client
X______________________________ Date: _________________

Counselors Signature

X______________________________ Date: _________________

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CLIENTS RIGHTS

As a client of Sassin and Associates In-Home Services home based program, you have certain rights that are set out in the OKDMHSAS Title 450, Chapter 15 Consumer Rights. Also, a written policy describes what this program must do to comply with said rights. A summary of your rights is below:

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

(2) Each consumer 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, and age, degree of disability, handicapping condition or sexual orientation.

(3) No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.

(4) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer 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 consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:
(A) Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;
(B) To be free from unnecessary, inappropriate, or excessive treatment;
(C) To participate in consumer'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 consumer's disorder.

(5) Every consumer's record shall be treated in a confidential manner.

(6) No consumer 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 consumer.

(7) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

(8) Each consumer 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 consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

The state has appointed an Advocate General who is responsible for the Office of Consumer Advocacy. The Advocate General shall assign an Advocate to monitor the care and treatment of individuals receiving services. The Advocate serves to ensure the highest quality of care to all consumers including but not limited to assisting a consumer in filing grievances. Consumer Advocates Office: 2401 N.W. 23rd Suite 85 Oklahoma City, OK. 73107-1-866-699-6605

I have informed this consumer of their Bill of Rights and they have received the synopsis of the consumer Bill of Rights. This consumer was given an opportunity to request a copy of the full Mental Health and Drug or Alcohol Abuse Services Bill of Rights (OAC450:15-3-2 through 450:15-3-25) and they:

____chose not to receive the full document. ____chose to receive an oral explanation of the synopsis in language that they can understand I accept ____ decline ____ a copy of the full Bill of Client Rights

Client over 14 years old________________________________ Date:___________________________________

Parent/Guardian: ______________________________________ Date: ____

Staff Signature/Credentials and Date:____

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GRIEVANCE AND APPEAL PROCEDURE

POLICY:
Every Client of Sassin and Associates has the right to present a complaint (grievance) or request a second opinion (appeal) on a staff decision made on the client's behalf.

PROCEDURE:

A. Clients of Sassin and Associates wishing to file a grievance or appeal should follow these procedures:
   1. If a client has a grievance or appeal, he or she orally (talking) or in writing, report the complaint to his or her counselor or the Local Advocate (Ines Maldonado or Jamie Weiland). A decision will be made on the complaint within 24 hours.
   2. If the client is not satisfied with the decision, the client may appeal to the Grievance Coordinator (Ruben Herron). Who is authorized to make decisions and will investigate the complaint with the counselor or other involved parties and make a decision within 24 hours.
   3. If the client does not agree with the Grievance Coodrinator's decision, the client may make his or her complaint or appeal in writing to the Executive Director John Sassin. The Executive Director must make a final decision in writing within 14 business days.

B. The client may at any time file a complaint with the client local advocate at DMHSAS consumer advocacy.

C. If the complaint involves the counselor, staff, grievance coordinator or facility advocate, the process involving them may be passed.

D. Client does not have to contact local advocate prior to contacting ODMHSAS Consumer Advocacy Division.

I have read or had read to me the procedure for handling a complaint at Sassin and Associates.

Signature of Client 14 and older_______________________ Date:___________________________

Parent/Guardian___________________________ Date: ________________________________

Provider:_____________________________ Date:_________________________________

Sassin and Associates
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CODE OF ETHICS

Sassin and Associates expects for employees, contractors and representatives of the agency to conduct themselves professionally at all times. Sassin and Associate employees should adhere to the following code of ethics:

1. All clients and guardians shall be allowed to participate in decisions regarding their care, services and treatment. Before services are rendered, information shall be provided to clients, to assist them informed consent.

2. Clients shall be provided with a copy of their rights including right to refuse services, participate in research and filing a grievance.

3. Decisions about care shall be based upon diagnostic and treatment need of the client solely.

4. The relationship between use of servicer and financial arrangements shall be monitored.

5. Grievance procedures shall be followed as prescribed in the grievance policy and clients shall not be retaliated against.

6. Adherence to resolving problems difference in treatment of care.

7. Confidentiality policy shall be followed at all times except in situations that fall within duty to warn.

8. Client's rights shall be observed at all times.

9. I consider the welfare of the client or group with whom I am working and their level of functioning as my primary obligation.

10. I give precedence to my responsibility for objectivity, integrity and high standards of care over my personal interests.

11. I will not discriminate among clients, staff, or professionals on the basis of race, ethnicity, gender, religion, creed, disability, age, sexual orientation or HIV status.

12. I consider that sexual or romantic intimacies between a client and myself are unethical and unprofessional. Likewise, I consider unethical and unprofessional any relationship that interferes with the purpose of the therapeutic relationship between the client and myself.

13. I will modify or terminate the therapeutic relationship between the client and myself when it is reasonable clear that the services I am providing to the client are not benefiting the client.

14. I hold myself responsible to be open and honest about the progress, treatment plans, and presenting problems of my clients with my supervisor and I will take adequate steps to prevent my personal problems from interfering with the services and welfare of my clients.

15. I will safeguard a client's right to confidentiality, abide Federal and State Confidentiality Requirements and I will reveal information received in confidence to certain other parties only after careful deliberation and consultation with my supervisor and when there is an imminent danger to the client or society always following legal guidelines.

16. I will abide by the Child Abuse and Neglect Reporting Requirements.

17. I hold myself responsible for informing clients of the limits of confidentiality.

18. I will conduct myself in a professional manner towards my colleagues and workers of other human services agencies and respect their rights and views.

19. I will do my best to make the client aware of his/her responsibility to comply with the financial arrangement established by Sassin and Associates.

20. I am committed to upholding the reputation of Sassin and Associates and its high standards of quality of care and supporting the agency in its efforts and contributions to the welfare of the community residents in need.

21. I will make periodic assessments of personal strengths, limitations, biases, and effectiveness and take responsibility for continued professional growth through education, training and self-assessment.

22. I will respect and follow agency policies and demonstrate a willingness to enhance the quality of agency services.

23. I will avoid conflicts of interest by abiding by the agency's private practice policy by not engaging in business or financial arrangements with clients and by not accepting gifts from clients.
24. I will carry out the duties of my position in accordance with statutory, accreditation, professional, and agency standards.
25. I will abide by the values and principles of the agency.

Client 14 or older: ___________________________ Date:_________________
Parent/ Guardian____________________________ Date:__________________
Provider:_____________________________________ Date:_________________

Sassin and Associates
2215 E. 21st St
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NOTICE OF PRIVACY PRACTICES

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice well be effective for all protected health information that we maintain at that time. In the event that the notice is changed a new notice will be sent to you by mail or the time of the next appointment. You may request a copy of our Notice at any time.

Uses and Disclosures of Protected Health Information

Sassin and Associates Uses and Disclosures of Protected Health Information Based Upon Your Written Consent.

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and disclosed, as needed, your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third party that has already obtained your permission to have access to your protected health information.

Payment: We may use and disclosed, as needed, your health information to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pay for mental health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you and undertaking utilization review activities.

Health Operations: We may use and disclosed, as needed, your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluation practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of you protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason expect those described in the Notice.

Emergencies: We may use or disclose *your* protected health information in an emergency treatment situation. In the event of *your* incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant *to* the person's involvement in *your* healthcare. If this occurs, the agency will try *to* obtain *your* consent as soon as reasonably practicable after the delivery of treatment.

Other permitted and Required Uses and Disclosures That May Be Made without Your Consent,

Authorization or Opportunity to Object

We may use or disclose *your* protected health information in the following situations without *your* consent or authorization. These situations include:

Required by Law: We may use or disclose *your* protected information *to* the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited *to* the relevant requirements of the law. You will be limited *to* the relevant requirement of the law. *You* will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose *your* protected health information *for* public health activities and purposes, *to* a public health authority that is permitted by law *to* collect or receive this information.

Health Oversight: We may disclose *your* protected health information *to* a health oversight agency for activities authorized by law, such as audits, investigation, and inspections.

Abuse or Neglect: We may disclose *your* protected health information *to* public health authority that is authorized by law *to* receive reports *of* child abuse or neglect. In addition, we may disclose *your* protected health information it we believe that *you* have been victim of abuse, neglect or domestic violence *to* the governmental entity or agency authorized *to* receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and states laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response *to* an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response *to* a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, *so* long as applicable legal requirement are met, *for* law enforcement purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose our protected health information, if we believe that the use or disclosure is necessary *to* prevent or lessen a serious and imminent threat *to* the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

National Security: We may disclose *to* military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose *to* authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution of law enforcement official having lawful custody of protected health information of inmate or client under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).
Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et seq.

I understand and had explained to me, how Sassin and Associates will use my protected health Information.

Client:______________________ Date:______________

Parent/Guardian:__________________ Date:_____________

Provider/Therapist:________________ Date:______________

Questions and Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may contact our Privacy Officer below for further information about the complaint process.
Privacy Officer: Jamie Weiland
Phone Number: 918-949-4430
Email: JamieLPC@CounselingInGreenCountry.com

Client 14 and over: ______________________________ Date:______________________________

Parent/Guardian: ________________________________ Date: ______________________________

Provider: _______________________________________ Date: ______________________________

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Disclosure of Health Information

Access: You have the right to inspect and copy your protected health information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. If your request copies, we will charge you $__.25___for each page, and $_15___per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may involve in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will abide by our agreement (except in an emergency).
We are not required to agree to a restriction that you may request. If we believe it is in your best interest not permit the use and disclosure of your protected health information, your protected health information will not be restricted.

Alternative Communication: You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You must make our request in writing. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we any prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operation as described in this Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

_______________________________________ Date: ___________
Client
____ Date: ___________
Parent/Authorized Representative Signature

Therapist: _____________________________ Date: ___________

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FEE SCHEDULE AGREEMENT

Client Responsibility Policy

I understand that I am expected to pay the agreed upon fee at the time services are rendered.

Proof of income may be required. (Copy of income tax return or recent pay stub.)

I will talk to my Counselor if I am unable to pay for any reason to abide by the above regulations.

___ I understand that I am expected to pay my insurance co-payment in the amount of $_________ at the time services are rendered. Claims will be submitted to my Insurance for reimbursement.

Insurance Company: ____________________ Policy#:_____________________
Group#________________

Member services #______________________________ Fax:
____

Self-Pay Clients:

___ Client Gross Income (Yearly) $ ______________ Family Size, including dependents ___________

___ Sliding Scale Fee has been adjusted to $________________

___ (We) agree to the (adjusted) fee of: Assessment Fee $__________ per session Fee $_________

Medicaid/SoonerCare
___ Sliding Scale Fee has been adjusted from 100% to 0%, due to: Consumer is eligible for Medicaid/ Medicare reimbursement for services.

Signature of Client 14 and older________________ Date:________________________

Parent/Guardian_____________________ Date: _____________________________

Provider: ________________________ Date:______________________________

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FIRE PLAN

If a fire is discovered in one of the rooms, the major objective is to protect the safety of clients and staff. The secondary objective is to preserve property.

1. If you discover a small fire, locate the nearest fire extinguisher and put out the fire.

2. If you discover a large fire, notify the receptionist to call 911 to report the fire and address of the facility.

3. Exit from the building shall be clearly marked with emergency evacuation routes are posted in the main waiting areas of each building and in staff offices.

4. A floor plan for each building shall be clearly marked with emergency evacuation routes are posted in the main waiting areas of each building and in staff offices.

5. All staff will be trained upon employment to the fire plan and the related procedures. Al staff will be informed of the nearest exit and how to evacuate clients in the most efficient manner.

6. In the event of a fire Executive Director and other available staff will secure clinical records. At which point the clinical records are secured they will be transported to a location designated by the Executive Director and kept under double lock and key. The current storage location for clinical records shall

Signature of Client 14 and older_______________________________ Date: _________________________________

Parent/Guardian____ Date: ____

Provider: ____ Date: ____

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Agreement to Follow Rules of Conduct

Upon my acceptance for services with Sassin and Associates., I agree to follow the rules of conduct as follows:

- To cooperate with admission procedures which includes: Intake Interview, verification of funding eligibility, Assessment, Treatment planning, and counseling services.
- To wear a seat belt when riding with Sassin and Associates staff.
- To follow Sassin and Associates policy's regarding a smoke free environment.
- I will not use alcohol, illegal substances of any kind while at Sassin and Associates offices or while riding in a vehicle in which I am receiving transportation from Sassin and Associates staff members.
- I will not use alcohol or drugs while participating in counseling session.

Client Signature ______________________________ Date ______________________

Parent/Legal Guardian _________________________ Date ______________________

Provider ___________________________________ Date ______________________

Client Certification – 3 Sections

1. Consent for Treatment

I, ______________________________________, do hereby certify, as evidenced by my initials below and my signature on page 21, that I:
Circle One: Client / Parent / Legal Guardian/Custodian

Hereby make application for voluntary admission to the services of SASSIN AND ASSOCIATES, as a voluntary client under the provision of OS 43A Section 9-101. I certify that I am 18 years of age or over. Voluntary admission may be made for any person 18 years of age or over on his or her own signature.

I have read, or had read to me, the following information about my rights: (A) All persons receiving services from this facility shall retain all rights, benefits, and privileges guaranteed by the laws and Constitution and State of Oklahoma and the United States of America, except those specifically lost through due process of law (OS 43A, Section 1-103) (H); (B) All persons shall have their rights guaranteed by the Clients Bill of Rights, unless an exception is specifically authorized by these standards or an order of a court of competent jurisdiction; (C) I have been given a summary or full copy of my rights as a client and fully understand the content of this document.

I have read, or had read to me, the following information about confidentiality and the limits thereof as pursuant to HIPAA and 43A O.S. Paragraph 3-422 and 3-418; and [U.S.] 42 CFR, Part 2. That by signing below, I consent to the use and disclosure of protected health information by Sassin and Associates., its' staff, and its' business associates for treatment, payment and health care operations.

I certify that a more detailed description or uses and disclosures for these purposes have been read by me, or read to me, from the Notice of Information Practices ("Notice").

I understand that I have the right to the "Notice" prior to signing this consent. I understand that the terms of this "Notice may change and if the terms do change, I may obtain a revised "Notice" by contacting Sassin and Associates., and requesting a revised "Notice". Sassin and Associates., will also post any revised "Notice" at their offices in Purcell, Oklahoma, Ada, Oklahoma, Wewoka, Oklahoma, Lawton, Oklahoma, or Tahlequah, Oklahoma.

I understand that I have the right to request that Sassin and Associates., restrict its' uses or disclosures of my protected health information which it is otherwise permitted to make for treatment, payment and health care operations, although Sassin and Associates., is not required to agree to these restrictions. However, if Sassin and Associates., agrees to further restrictions, they are binding on Sassin and Associates.

I understand that I have the right to revoke this consent in writing, except to the extent that Sassin and Associates., has taken action in reliance on it.

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 client of this agency be charged for care and treatment provided. I have been given a copy of the current rate schedule and I understand that payment on all charges is adjustable according to my ability to pay. No individual will be refused needed treatment because of inability to pay (OS 43A, Section 4-202).

I understand that I may refuse a particular service but that my refusal, if any, will not preclude me from accessing other mental health and/or substance abuse services I might need.

I understand that I will be periodically contacted during my treatment to give an assessment of my progress or lack there of to assist SASSIN AND ASSOCIATES in providing better services.

I understand that I am free to withdraw consent at anytime.

Client Initials & Date ____________________ **Parent and/or Legal Guardian Initials & Date** ____________________
(age 14 and over)

CLIENT: LAST NAME ________________________________ **FIRST** ________________ **MI** ______ **ID#** ______________________

2. Consent for Follow Up

I, ______________________________, do hereby certify, as evidenced by my initials below and my signature on page 21, that I:
Circle One: Client / Parent / Legal Guardian/Custodian

Agree to participate in two follow-up surveys during the year after my treatment. This survey will let SASSIN AND ASSOCIATES know how I am doing.

One follow-up will be conducted when I have been discharged for three months and the other after I have been discharged for one year. My survey forms will not be marked to ensure my Confidentiality although I will be able to provide my contact information if I should wish to do so, and the responses will be kept strictly confidential. SASSIN AND ASSOCIATES will combine and summarize survey information from all responding clients in order to show how effective the treatment was and what improvements may need to be made.

I understand that my current treatment will be continued regardless of whether I agree to participate in the surveys. My participation is strictly voluntary. I am free to withdraw at any time. If I have any questions concerning this survey, I may contact a representative of SASSIN AND ASSOCIATES or the Advocate General for the Oklahoma Department of Mental Health and Substance Abuse Services at 405-522 -4256or toll-free 1(866) 699-6605.

___I consent to participate in this survey by (check one):

___mailed questionnaire ___telephone interview ___in-person interview

___I decline to participate in this survey.

Below I am providing an address and phone where I believe I can be located in the future and the names and addresses of others who may be of help in contacting me. I understand that all information I provide will be kept confidential, that those persons whose names I provide will only be contacted concerning my whereabouts and that my treatment or condition will NOT discussed with them or anyone else.

I expect to live at:______________________________, __________________, ____________, ________________
Street City State Zip Code

(_______) - _______ - ___________________
Area Code Telephone Number

Other person(s) living at that address : ______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

Client Initials & Date ____________________
(age 14 and over)

Parent and/or Legal Guardian Initials & Date ____________________

CLIENT: LAST NAME ______________________________ **FIRST** ________________ **MI** ______ **ID#** ______________________

Sassin & Associates, Inc.
HIV / AIDS / STDS / Hep C / TB

Circle the best answer for you.

I **do want** additional **HIV/AIDS/STDS/Hep C/TB** education or information for myself. Yes No

I **do want** additional **HIV/AIDS/STDS/Hep C/TB** education or information for my significant other. Yes No

Circle the best answer for you.

I **do** want to have **HIV / AIDS / STDS/ Hep C/ TB** counseling arranged for me at this time. Yes No

I **do** want to have **HIV / AIDS/ STDS/ Hep C/ TB** counseling arranged for my significant other at this time. Yes No

Circle the best answer for you.

I **do** want to have **HIV / AIDS/ STDS/ Hep C/ TB** testing arranged for me at this time. Yes No

I **do** want to have **HIV / AIDS /STDS /Hep C / TB** testing arranged for my significant other at this time. Yes No

My signature below indicates that I have gone over and received a copy of the information on **HIV /AIDS /STD /Hep C /TB,** which includes but is not limited to high risk behaviors, ways to protect oneself, and how to get tested.

My signature below also indicates that I understand that **at any time**, I can ask my provider or any member of the SASSIN AND ASSOCIATES staff for additional education or information, or for help to arrange testing.

My signature below also indicates my understanding that for any method of testing I may request, I will be referred to my local Health Department by SASSIN AND ASSOCIATES staff. (For RSAT clients, referral will be made to a DOC Case Manager with clients request.)

____ ____________________________
Client Signature Date

____ ____________________________
Staff Signature Date

THIS PAGE FOR USE BY AODTP ONLY WITH SUBSTANCE ABUSE TREATMENT CLIENTS

CLIENT: LAST NAME ____________________ **FIRST** ____________ **MI** ____ **ID#** ______________