

Patient's Name _____

Adolescent Behavioral Health Admission 1

Date: ____/____/____

Time: _____

Admitting Physician: _____

Admit type: Adolescent

Room Number: _____

Provisional Diagnosis: _____ Referral Source: _____

Patient Name: _____

Sex: M or F

Ethnicity: _____ Religious Preference: _____

DOB: ____/____/____ Age: ____ SSN: ____-____-____ Marital Status: S M D W

Mailing Address: _____

Physical Address: _____

Home #: _____ Work #: _____ Cell #: _____

Who has legal custody of the patient? Mother Father Both CPS/ Social Services

Other: _____

Who has physical custody of the patient? Mother Father Both CPS/Social Services

Grandparents Foster Parents Other: _____

Was the documentation of legal custody received? Y or N

Are the biological parents married to one another? Y or N

If yes, list both parents.

If no, are the biological parents remarried? Y or N

If yes, list ALL step-parents information.

Primary care Physician: _____

PCP Address: _____ Phone Number: _____

Patient's Name _____

Adolescent Behavioral Health Admission 2

Biological Mother's Name: _____ **Maiden Name:** _____

DOB: _____

Mother's Mailing Address: _____

Mother's Physical Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Mother's Employer: _____ **Occupation:** _____

Employer's Address: _____

Biological Father's Name: _____

DOB: _____

Father's Mailing Address: _____

Father's Physical Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Father's Employer: _____ **Occupation:** _____

Employer's Address: _____

Non-Bio Parent's Name: _____ **Relationship to PT:** _____

Parent's Mailing Address: _____

Parent's Physical Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Parent's Employer: _____ **Occupation:** _____

Employer's Address: _____

Non-Bio Parent's Name: _____ **Relationship to PT:** _____

Parent's Mailing Address: _____

Patient's Name _____

Adolescent Behavioral Health Admission 3

Parent's Physical Address: _____

Home #: _____ Work #: _____ Cell #: _____

Parent's Employer: _____ Occupation: _____

Employer's Address: _____

Foster Parent's Name: _____

Foster Parent's Mailing Address: _____

Foster Parent's Physical Address: _____

Home #: _____ Work #: _____ Cell #: _____

Parent's Employer: _____ Occupation: _____

Employer's Address: _____

Patient's School: _____ School Phone #: _____

School Address: _____

Guarantor Name: _____ Home Phone #: _____

Guarantor's Address: _____

Guarantor's Employer: _____ Occupation: _____

Employer's Address: _____ Work #: _____

Primary Insurance: _____ ID #: _____

Subscriber's Name: _____ DOB: _____

SSN: _____

Group #: _____ Phone #: _____

Mental Health Carve Out: _____ Phone #: _____

Billing Address: _____

Case Manager: _____ Phone #: _____

Patient's Name _____

Adolescent Behavioral Health Admission 4

Authorization #: _____ # of Days Authorized: _____

Notes:

Secondary Insurance: _____ ID #: _____

Subscriber's Name: _____ DOB: _____

SSN: _____

Group #: _____ Phone #: _____

Mental Health Carve Out: _____ Phone #: _____

Billing Address: _____

Case Manager: _____ Phone #: _____

Authorization #: _____ of Days Authorized: _____

Notes: _____

Emergency Contact #1: _____ Relationship to PT: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact # 2: _____ Relationship to PT: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

CONDITIONS OF ADMISSION/TREATMENT AGREEMENT

I, the Patient or the person authorized to act for the Patient, agrees to the following terms of admission and/or treatment at the healthcare facility. The term "healthcare facility" means the location of care where I'm currently registering to receive healthcare services

1. **GENERAL INFORMED CONSENT:** I consent to Patient receiving routine healthcare services/treatment ordered by the provider responsible for the Patient's care. I understand treatment may be provided by physicians, medical students, licensed independent practitioners, nurses, students or other individuals functioning within their approved scope of practice. I agree that this consent to treatment will be valid until Patient is discharged from the healthcare facility. _____ (Please initial).
2. **PHYSICIANS:** I understand that physicians responsible for the Patient's care may not be employees or agents of the healthcare facility, and may be independent contractors. I understand that Patient's physicians are responsible for their own treatment activities, and that the healthcare facility is not liable for the actions or omissions of physicians that are not employees of the healthcare facility. I accept responsibility to ask any physician whether the physician is an independent contractor or healthcare facility employee.
3. **EMERGENCY SERVICES NOTICE:** I understand that if Patient comes to the healthcare facility or healthcare facility emergency department, requesting treatment for an emergency medical condition, the healthcare facility is obligated to provide a medical screening examination and any stabilizing treatment or transfer, whether or not Patient has the ability to pay for these services.
4. **RELEASE OF INFORMATION:** Northern Arizona Healthcare's Notice of Privacy Practices has information about how the organization may release Patient's health information. I acknowledge that I have received a copy of the Northern Arizona Healthcare's Notice of Privacy Practices. I understand I may be contacted by an outside patient satisfaction agency, on behalf of Northern Arizona Healthcare, concerning my patient experience. _____ (Please initial).
5. **CONSENT TO RECORD, PHOTOGRAPH, OR FILM:** I give consent to the healthcare facility for recording, photographing, or filming the Patient for purposes of treating patient, or for the healthcare facility's internal operations, such as improvement of quality of care, and educating students and professionals.
6. **PERSONAL ITEMS AND BELONGINGS:** The healthcare facility does not accept any responsibility for personal belongings. If admitted to the hospital, the hospital has a safe in which Patient may store money and other valuables. The maximum liability in case of loss or damage for items deposited in the safe is \$500. Northern Arizona Healthcare is not responsible for loss or damage to any items that are not deposited in the safe by Patient, such as money, jewelry, eye glasses, dentures, hearing aids, contact lenses, or documents. The healthcare facility will dispose of any property that remains in the safe for five (5) years or more under the Uniform Unclaimed Property Act (A.R.S. 44-301, et. seq.). _____ (Please initial).
7. **FINANCIAL AGREEMENT:** I agree that in return for services provided to Patient, the Patient is responsible for any health insurance deductibles and co-payments. The payment of deductibles and co-payments may be requested at the time of service. The Patient agrees to pay Patient's account in full. When practical the healthcare facility healthcare will bill the Patient's insurance for services provided. **Assignment of benefits:** If Patient is entitled to any benefits from an insurance policy that insures Patient or any other party liable to Patient, Patient assigns the benefits to the healthcare facility. The Patient also assigns to the healthcare facility the rights to payment for the charges of the physician(s) for whom the healthcare facility is authorized to bill in connection with its services. I understand that I remain responsible for payment of the bill regardless of this assignment of insurance coverage. **Price quotes:** I understand that any price quotations given are estimates of expected services. The price quotes may not include physician fees for services. Price quotes may vary significantly from actual charges, which are based on the treatment ordered by Patient's physician(s), the provider responsible for the Patient's care, and Patient's actual medical conditions. **Physicians:** I also understand that most physicians will bill separately from the healthcare facility. Patient's physicians may or may not participate with the same insurance plans as the healthcare facility which could affect the reimbursement made by Patient's insurance carrier for these physicians' services. **Lien rights:** I understand that if the healthcare facility is providing services to Patient as a result of an accident or the negligent or wrongful acts of another, the healthcare facility may have a lien on any judgment, damages, or settlement recovered by Patient for the healthcare facility full billed charges. I agree to provide the healthcare facility with any information necessary for the healthcare facility to pursue its' statutory lien or secure payment for Patient's insurer and understand that if I fail to provide necessary information, I may be personally responsible for the healthcare facility full bill. I also understand that CMS may initiate a lien and that the healthcare facility must comply with any lien rights or reporting requirements of CMS. **Collections:** I agree to pay reasonable attorney's fees and collection expenses if the account is sent to an attorney or collection agency. I understand that the healthcare facility may charge a delinquent account interest at the legal rate.
8. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I also understand that adult patients have the right to make advance directives that will direct care in the event they are unable to make their own health care decisions. Please read and check the appropriate statements below.

Patient has the following advance directive(s): (Initial or check those that pertain)

_____ Living Will _____ Health Care Power of Attorney _____ Mental Health Care Power of Attorney
_____ Pre-healthcare Facility Medical Care Directive _____ Written Consent - Patient Representative

_____ Patient has provided the healthcare facility with a copy of the above advance directive(s).

_____ Patient has not executed an advance directive. Patient has been offered written material on advance directives.

_____ Patient or Authorized Party does not know if Patient has an advance directive.

9. **CHANGES TO THIS FORM:** Personnel handling Patient's admission to the healthcare facility do not have authority to agree to any changes to this Condition of Admission form. To discuss changes to this form, contact the Central Business Office Director or designee.

THE UNDERSIGNED CERTIFIES:

- (1) I HAVE READ AND UNDERSTAND THESE CONDITIONS OF ADMISSION, INCLUDING PATIENT'S/PATIENT REPRESENTATIVE'S BILL OF RIGHTS ON THE BACK OF THIS PAGE;
- (2) I HAVE RECEIVED OR BEEN OFFERED A COPY OF THESE CONDITIONS OF ADMISSION;
- (3) I AM THE PATIENT OR I AM THE LEGAL REPRESENTATIVE OF THE PATIENT AND AM AUTHORIZED TO SIGN THIS AGREEMENT ON BEHALF OF THE PATIENT; AND
- (4) I AGREE TO ALL TERMS IN THESE CONDITIONS OF ADMISSION.

Patient or Patient Representative Printed Name and Signature*

Date and Time of Signing

* If you are the Patient's Representative, please check the box indicating your authority to act on behalf of Patient and provide copy of applicable documents:

- ☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney ☐ Mental Health Care Power of Attorney ☐ Written Consent of the Patient
☐ Patient does not have the capacity to make health care decisions or is being admitted in an emergency, and I have the following surrogate relationship
with Patient: _____
☐ Other (explain): _____

Northern Arizona Healthcare

Check box when completing manually

☐ Flagstaff Medical Center ☐ Verde Valley Medical Center

CONDITIONS OF ADMISSION/ TREATMENT AGREEMENT

Place Patient Label Here



COA

Conditions of Admissions

PR-006-1 (03/25/2014)

Approved By Document Control Committee

Reviewed 12/12/2013 Revised 3/25/2014

CONDITIONS OF ADMISSION/TREATMENT AGREEMENT

PATIENT'S/PATIENT REPRESENTATIVE'S BILL OF RIGHTS

Patient/Patient Representative:

1. **HAS THE RIGHT** to be informed of the patient's rights at the time of admission and in advance of furnishing or discontinuing care.
2. **HAS THE RIGHT** to receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.
3. **HAS THE RIGHT** to care in a comfortable environment with respect to privacy, dignity, and his/her personal values, beliefs, choices, strengths, and abilities under the supervision of competent, qualified, and experienced clinical staff;
4. **HAS THE RIGHT** to make informed decisions regarding all aspects of his/her medical care, including the decision to accept, refuse or limit treatment, to the extent permitted by law, to be informed of the medical consequences of his/her action, and to delegate his/her right to make informed decisions to another person.
5. **HAS THE RIGHT** to participate in the development, periodic review, and implementation of his/her individualized plan of care/program plan and to be informed of his/her health status, including diagnosis, treatment and prognosis, in terms that he/she can understand.
6. **HAS THE RIGHT** to receive from his/her physician information necessary to give specific informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for specific informed consent should include, but not be limited to, the specific procedure(s) and/or treatment, alternatives to the medical procedure(s) and/or treatment, associated risks, and possible complications.
7. **HAS THE RIGHT** to be informed about outcomes of care whenever those outcomes differ significantly from the anticipated outcomes.
8. **HAS THE RIGHT** to have pain assessed and managed when admitted and throughout patient's healthcare hospitalization.
9. **HAS THE RIGHT** to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be the least restrictive method and discontinued at the earliest possible time.
10. **HAS THE RIGHT** to expect that the healthcare facility will provide a mechanism whereby the patient is informed by the physician or an agent of the physician of a referral or transfer to another facility when medically appropriate, or of discharge plans, including any continuing health care requirements following the patient's discharge.
11. **HAS THE RIGHT** to make an informed decision on whether to participate in an investigative study, research project, experimental treatment, clinical trial, or educational activity related to his/her care or treatment. A refusal to participate will not compromise access to service.
12. **HAS THE RIGHT** to have a family member or representative of his/her choice and his/her physician notified as soon as can be reasonably expected of the patient's admission to the healthcare facility. The patient has the right to have access to a phone, and involve or exclude family members from care decisions.
13. **HAS THE RIGHT** to formulate advance directives and to have healthcare facility staff and physicians comply with these directives.
14. **HAS THE RIGHT** to participate and to assist in resolving ethical issues or dilemmas that arise in his/her care (i.e., issues of conflict resolution, provision of futile care, withdrawing of life-sustaining treatment, etc.).
15. **HAS THE RIGHT** to prompt resolution of a grievance. The healthcare facility will not retaliate against a patient or representative for filing a grievance with either the healthcare facility or Arizona Department of Health Services. Please notify your care providers of unmet care needs or care concerns. If your needs or concerns are not met, you may request to speak with a Patient Relations Representative (FMC dial (928) 779-3366 ext: 13528; VVMC or SMC dial (928) 639-6000 ext: 36263) and/or file a grievance with the Arizona Department of Health Services, Division of Licensing, Medical Facilities Licensing, 150 N. 18th Ave., 4th Floor, Suite 450, Phoenix, AZ, 85007. Phone: (602) 364-3030
16. **HAS THE RIGHT** to receive care in a safe and secure healthcare facility environment and to be free from all forms of discrimination, abuse or harassment from staff, other patients or visitors.
17. **HAS THE RIGHT** to review the patient's own medical record, as permitted by law. To confidentiality with respect to communications and records regarding his/her health care and to access the information, as permitted by law, in the medical record. The healthcare facility's Notice of Privacy Practices describes how the healthcare facility can use and disclose protected health information, the patient's rights under the HIPAA Privacy Standards, and the healthcare facility's legal duties regarding protected health information.
18. **HAS THE RIGHT** to obtain a schedule of healthcare facility healthcare facility rates and charges, examine and receive an explanation of his/her bill regardless of source of payment.
19. **HAS THE RIGHT** to obtain information regarding the relationship of the healthcare facility to other health care providers, education institutions, and payers, as far as his/her care is concerned.
20. **HAS THE RIGHT** to know what healthcare facility rules and regulations apply to patient's conduct.
21. **HAS THE RIGHT** to a full explanation of any restrictions, including clinical restrictions, placed by the healthcare facility on a patient's visitors, mail, telephone calls, or other forms of communication.
22. **HAS THE RIGHT** to access protective services. Local community protective service agencies may assist patient in determining whether protective services are needed and how to correct hazardous living conditions or situations.
23. **HAS THE RIGHT** subject to his or her consent (which may be withdrawn at any time), to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend.

PATIENT'S/PATIENT REPRESENTATIVE'S RESPONSIBILITIES

Patient/Patient Representative:

1. **IS RESPONSIBLE** for providing, to the best of his/her knowledge, accurate and complete information about the patient's health care status including current copies of Advanced Directives that include: Living Will, Health Care Power of Attorney, Mental Health Care Power of Attorney, Pre-healthcare facility Medical Care Directive, and Consent for Patient Representative.
2. **IS RESPONSIBLE** for reporting perceived risks in the patient's care and unexpected changes in the patient's condition.
3. **IS RESPONSIBLE** for following the care, service, or treatment plan developed. The patient/representative should express any concerns or questions about his/her ability to follow and comply with the proposed care plan.
4. **IS RESPONSIBLE** for following the healthcare facility's rules and regulations concerning patient care and conduct and for being considerate of the healthcare facility's personnel and property.
5. **IS RESPONSIBLE** for providing, to the best of his/her knowledge, accurate and complete information to allow payment of healthcare facility's charges and, as applicable, for promptly meeting any financial obligation agreed to with the healthcare facility.
6. **IS RESPONSIBLE** to notify his/her care providers of unmet care needs or care concerns.

Northern Arizona Healthcare

Rights of Persons with Serious Mental Illness

Civil and Other Legal Rights

I have the right to acquire and dispose of property, execute instruments, enter into contractual relationships, hold professional, occupational or vehicle operator licenses, unless adjudicated otherwise. I have the right to be free from unlawful discrimination on the basis of race, creed, religion, sex, and sexual preference, and age, physical or mental handicap. I have the right to equal access to all existing behavioral health services, community services, and generic services. I have the right to religious freedom and practice. I have the right to vote. I have the right to reasonable access to a telephone and opportunities to make and receive confidential calls and assistance when desired and necessary. I have the right to unrestrictedly send and receive uncensored and unopened mail, to be provided stationery and postage to the extent reasonable, and help in exercising this right. I have the right to be visited and visit with others within reasonable restrictions to protect the privacy of others and avoid serious agency disruptions. I have the right to associate with anyone of my choice, to form associations, and to discuss, along with the group with management, matters of general interest. I have the right to privacy, including not be fingerprinting or photographing without authorization. I have the right to be informed, in appropriate language and terms, of my rights. I have the right to state my grievances when I feel my rights have been violated, including when such grievances have not been considered in a fair, timely, and impartial procedure. I have the right to not be retaliated against for filing a grievance. I have the right of access to a human rights advocate. I have the right to be assisted by an attorney or designated representative of my choice, including the right to meet in a private area with the same. I have the right to exercise all other rights, entitlements, privileges and immunities provided by law. I have the same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of my choice without constraints upon independence, except those to which all citizens are subject.

Support and Treatment

I have the right to behavioral health services or community services under conditions that support my personal liberty and restrict same only as provided by law. I have the right to receive support and treatment from a flexible service system provided in a way that preserves my dignity, respects my individuality, abilities, needs, and aspirations, and encourages my self-determination, freedom of choice, and participation in treatment to my fullest capacity. I have the right to assurance of freedom from the discomfort, distress and deprivation that arise from an unresponsive and inhumane environment. I have the right to have my privacy protected and promoted, including-when-ever possible-private living, sleeping and personal care spaces. I have the right to treatment which maximizes integration into my community and offers humane and adequate support and treatment which is least restrictive, culturally sensitive, voluntary, and home-based to the extent possible with opportunities for normalized experience.

I have the right to ongoing participation in the planning of services and revision of my individual service plan. I have the right to a reasonable explanation of all aspects of my condition and treatment. I have the right to give informed consent and to refuse services. I have the right not to participate in experimental treatments. I have the right to a humane treatment environment that protects me from harm, provides privacy and freedom from verbal or physical abuse. I have the right to enjoy basic good and services without threat of denial or delay. I have the right to be informed, in advance, of charges for services. I have the right to a continuum of care in a unified and cohesive system of services that is well integrated, and not limited...which includes clinical case management, outreach, training and opportunities, day treatment, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance. I have the right to other programs that offer different levels of intensity of services, to treatment, based on my individual and unique needs, to services provided in the most normal and least restrictive setting, and to clinical case management services and a case manager. I have the right to participate in treatment decisions and in the development and implementation of my ISP as well as the type and location of services. I have the right to prompt consideration of discharge from an inpatient facility and the identification of steps necessary to secure same. I have the right to be represented by a qualified advocate or other designated representative of my choice in the development of the ISP and the inpatient treatment and discharge plan and in the grievance process.

Protection from Abuse, Neglect, Exploitation, and Mistreatment

I have the right to be free from abuse, neglect, exploitation, and mistreatment. Mistreatment includes but is not limited to: abuse, neglect, or exploitation; corporal punishment; any other unreasonable use or degree of force or threat of force not necessary to protect me or another; infliction of mental or verbal abuse, such as screaming, ridicule, or name calling; incitement or encouragement of others to mistreat me; transfer or the threat of transfer for punitive reasons; restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; any act in retaliation for reporting a violation, or commercial exploitation.

Restraint and Seclusion

I have the right to be free from restraint or seclusion other than that permitted by and in compliance with Chapter 9, A.A.C. 20 and other applicable federal or state law.

Labor

I have the right to be free from performing labor which involves the essential operation and maintenance of the service provider.

Competency and Consent

I shall not be deemed incompetent solely by reason of admission to a mental health agency.

Informed Consent

I have the right to provide voluntary, informed consent for psychotropic medication, E.C.T, telemedicine, participation in research, admission for detoxification, and inpatient/residential admission.

Medication

I have the right to be free from unnecessary or excessive medication, medication used as punishment, for the convenience of staff, or as a substitute for other behavioral services. I have the right to the least amount medically necessary, prescribed by a physician/psychiatrist, to be seen monthly (or as otherwise designated in my ISP) and written evaluation relative to dosage, medication mixture, signs of tardive dyskinesia or other effects, the reason, and the effectiveness. I have the right to self-administer my medications unless otherwise restricted. I have the right to be free from PRN orders for medication used as a restraint.

Property and Possessions

I have the right to acquire, retain and dispose of personal property, including the right to maintain a bank account unless under guardianship, conservatorship, representative payee or a court order.

Records

I have the right to privacy of my records and disclosure only with appropriate authorization under the law.

ADOLESCENT IMMUNIZATION RECORDS

Date of Admission: _____

Date of First Immunization Request: _____

Request from Parents: _____

School: _____

Primary Care Physician: _____

Result of Request: _____

If first request not received within 48 hours from admit then:

Date of School Immunization Record Request: _____

Requested from Parents: _____

School: _____

Primary Care Physician: _____

Result of Request: _____

Flagstaff Medical Center Behavioral Health Services Fax No: 928-213-6301



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the health record of:
(Enter Hospital name or Clinic name)

PATIENT INFORMATION	Patient Name _____		Date of Birth _____	MRN # _____ (for internal use only)
	Address _____		Area Code and Phone Number _____	
	City _____	State _____	Zip Code _____	
INFORMATION REQUESTED	Service Dates From: _____ To: _____			
	<input type="checkbox"/> All Pertinent Records <input type="checkbox"/> Allergies <input type="checkbox"/> Consultation <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ER Report <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical <input type="checkbox"/> Laboratory <input type="checkbox"/> Medication List <input type="checkbox"/> Other _____		<input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Discharge Instructions <input type="checkbox"/> X-ray Images <input type="checkbox"/> Billing Record <input type="checkbox"/> Entire Medical Record	
	I authorize the provider to disclose information related to: (check all that apply) <input type="checkbox"/> Behavioral Health/Psychiatric/Mental Health Information <input type="checkbox"/> AIDS/HIV and Other Communicable Disease <input type="checkbox"/> Alcohol and/or Substance Abuse Screening and/or Treatment <input type="checkbox"/> Genetic Testing Method of Delivery <input type="checkbox"/> _____ <input type="checkbox"/> Call When Ready <input type="checkbox"/> Paper Request <input type="checkbox"/> CD			
CLINIC RECORDS	<input type="checkbox"/> Clinic Notes <input type="checkbox"/> Discharge Summary		<input type="checkbox"/> H & P <input type="checkbox"/> OP Report <input type="checkbox"/> Lab Tests <input type="checkbox"/> Progress Notes <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Others	
PURPOSE	<input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Workmen's Compensation		<input type="checkbox"/> Insurance Coverage <input type="checkbox"/> Other: _____	
INFORMATION to be VIEWED BY OR GIVEN TO	Company, Person, Facility _____		Area Code and Phone Number _____	
	Street Address _____		Area Code and Fax Number _____	
	City _____	State _____	Zip Code _____	
<p>I may refuse to sign this authorization form. I understand that the Facility will not condition or deny treatment on my signing this authorization.</p> <p>I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Healthcare/Psychiatric Care, Treatment of Alcohol and/or Drug Abuse, and Genetic Testing; My signature authorizes release of any such information.</p> <p>I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Unless I revoke this authorization earlier, it will expire in one year. To revoke my authorization, I must submit a written request to the Medical Records Custodian at the applicable facility: Flagstaff Medical Center, 1200 N. Beaver St., Flagstaff, AZ 86001; Verde Valley Medical Center, 269 S. Candy Lane, Cottonwood, AZ 86326 or Northern Arizona Home care, 107 E. Oak Avenue, Flagstaff, AZ 86001.</p> <p>I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.</p> <p>I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.</p> <p>This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.</p>				
Patient Signature _____		Date _____	Patient Authorized Representative Signature _____	
<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Surrogate Decision Maker		<input type="checkbox"/> Patient Representative <input type="checkbox"/> Minor <input type="checkbox"/> Patient Deceased		
For Healthcare Use Only				
Employee completed/reviewed form with patient: _____			ID verified _____	
Date Received: _____	Date Sent: _____	Date Faxed _____	# of pages _____	
Copy Service: _____	Date Copied: _____	Completed By: _____	Emailed to Copy Service on: _____	



ROI



Flagstaff Medical Center
Northern Arizona Healthcare

CONSENT FOR ADOLESCENT PROGRAM

I have received information regarding the following:

- | | |
|---|--|
| <input type="checkbox"/> Visiting Hours | <input type="checkbox"/> Phone Times |
| <input type="checkbox"/> Contraband Items | <input type="checkbox"/> Time-Out System |
| <input type="checkbox"/> Restraint / Seclusion | <input type="checkbox"/> Recreational Outings |
| <input type="checkbox"/> Medication Policy | <input type="checkbox"/> Searches |
| <input type="checkbox"/> Copy of Patient Bill of Rights | <input type="checkbox"/> Copy of Grievance Policy |
| <input type="checkbox"/> Quiet Time | <input type="checkbox"/> Copy of Pertinent Telephone Contact #'s |
| <input type="checkbox"/> Copy of Inpatient Adolescent Unit Handbook (Quest Program) | |

☐ In the event of an emergency and I cannot be reached by telephone, I give my consent to allow psychiatric medications to be administered to my child. I understand that such use will be explained to me at the first opportunity and that I may revoke consent at any time.

☐ I understand that my child will be subject to these policies and possible treatment interventions while a patient on the locked psychiatric unit.

☐ I give my permission to have my child photographed for patient identification purposes.

☐ If the patient is enrolled in a Regional Behavioral Health Authority and Seriously Mentally Ill, I have received a copy of the Right For Persons With a Serious Mental Illness (initial if applicable)

Parent / Legal Guardian Signature

Date/Time

Parent / Legal Guardian Signature

Date/Time

BHS Staff Signature

Date/Time

Flagstaff Medical Center

1200 North Beaver Street • Flagstaff, Arizona 86001

**CONSENT FOR
ADOLESCENT PROGRAM**

Place Patient Label Here



CNS

DP-1089 (06/30/14)



Flagstaff Medical Center
Northern Arizona Healthcare

CONSENT FOR ADOLESCENT PROGRAM

I have received information regarding the following:

- | | |
|---|--|
| <input type="checkbox"/> Visiting Hours | <input type="checkbox"/> Phone Times |
| <input type="checkbox"/> Contraband Items | <input type="checkbox"/> Time-Out System |
| <input type="checkbox"/> Restraint / Seclusion | <input type="checkbox"/> Recreational Outings |
| <input type="checkbox"/> Medication Policy | <input type="checkbox"/> Searches |
| <input type="checkbox"/> Copy of Patient Bill of Rights | <input type="checkbox"/> Copy of Grievance Policy |
| <input type="checkbox"/> Quiet Time | <input type="checkbox"/> Copy of Pertinent Telephone Contact #'s |
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Parent / Legal Guardian Signature

Date/Time

Parent / Legal Guardian Signature

Date/Time

BHS Staff Signature

Date/Time

Flagstaff Medical Center

1200 North Beaver Street • Flagstaff, Arizona 86001

**CONSENT FOR
ADOLESCENT PROGRAM**

Place Patient Label Here



CNS

DP-1089 (06/30/14)

Adolescent Contact List

Adolescent visitation with parents/guardian ONLY, unless previously arranged with Charge RN or Counselor. 24 hours advanced notice
ADOLESCENT PHONE PRIVILEGE TO PARENTS/GUARDIANS EXCLUSIVELY UNTIL SELF-AWARENESS PHASE OBTAINED

NAME	RELATIONSHIP	ADDRESS	PHONE #	PHONE CALLS	VISITS
	Parent/ Legal Guardian				
	Parent/ Legal Guardian				
	Parent/ Legal Guardian				
	Parent/ Legal Guardian				
* If your child obtains self-awareness phase, he/she may receive phone calls only from the following contacts:					

Parent or Legal Guardian Signature

Date _____

Flagstaff Medical Center
Behavioral Health Services
1200 N. Beaver Street * Flagstaff, AZ 86001
Contact List
BH - 04

Place Patient Label Here



Flagstaff Medical Center
Northern Arizona Healthcare

INFORMED CONSENT FOR PSYCHOTHERAPY/COUNSELING

I hereby voluntarily consent to utilize the services provided by my therapist/counselor. Possible services include: Individual counseling/psychotherapy, marital therapy, family therapy, group therapy, psychological consultation and psychological testing. I understand my therapist is not warranting a cure or offering any guarantee of results or improvement of my condition.

ASSUMPTION OF RISKS:

As a patient utilizing the services of a mental health professional, I understand that I have a right to ask any questions I may have about my plan of care. In addition, I understand I have the right to terminate therapy at any time. I understand that potential benefits of undergoing psychological services include obtaining a professional opinion, increased understanding of myself, and relief of symptoms. I understand potential risks include discussion of material that may be "difficult and painful", and that positive results are not guaranteed. I understand and agree that my continued participation in therapy implies voluntary informed consent. I understand that alternative procedures include services provided by another mental health professional.

LIMITS OF CONFIDENTIALITY:

All communication and records which involve mental health treatment are confidential. No one from this hospital or clinic may release any information except under the following special circumstances:

- (1) upon express written consent of the patient or legal guardian of a minor patient;
- (2) if release is ordered by a court, or if the patient introduces their mental status into issue in a lawsuit;
- (3) if there is sufficient reason to suspect that abuse or neglect of a child, or elderly, disabled or incompetent individual is occurring;
- (4) upon the need to disclose information to protect the rights and safety of self or others if a patient indicates he/she may present a danger to self or others. In such circumstances, possible actions could include notification of a family member, notification of law enforcement authorities, notification of individual(s) at risk of harm, or arrangement for voluntary or involuntary hospitalization of the patient;
- (5) if necessary to collect fees owed for professional services rendered, provided that only information relevant to the financial resolution may be disclosed; and in accordance with HIPPA regulations;
- (6) if legal proceedings or complaints with a licensing board or regulatory body are initiated against the mental health professional. In that unlikely event, information necessary for response to such a claim or action may be disclosed.

PRIVACY OF OTHERS:

I understand that if I am a participant in a therapy group that I will be encouraged to share information about myself related to the problem which brings me here for treatment. I will also hear information shared by other group members. It is expected that I will keep entirely private/confidential any such information that I hear about or from other patients.

RELEASE OF INFORMATION: PATIENT/PARENT/GUARDIAN:

While the patient has the legal right to the information contained in the medical record, this information will be given to the patient only after a clinician has reviewed the information. A written patient authorization must be secured.

MANAGED CARE CONTRACTS:

I understand that this hospital or clinic may have contracts with several managed care companies and preferred provider organizations and that FMC may exchange any and all information pertaining to this case with a managed care company representative(s) when disclosure is necessary for case management, claims processing, coordination of treatment, quality assurance or utilization review purposes and only in accordance with HIPPA Regulations.

STATEMENT OF UNDERSTANDING:

My signature below indicates I have read this form or it has been read and explained to me and that I fully understand the above information and that I consent for either myself or for a minor child for whom I am legally responsible to receive services.

Patient or Legal Guardian

Date

Flagstaff Medical Center

1200 North Beaver Street • Flagstaff, Arizona 86001

**INFORMED CONSENT FOR
PSYCHOTHERAPY/COUNSELING**

Place Patient Label Here



BHU

Informed Consent for Psychotherapy/Counseling

Approved By Document Control Committee

Reviewed 10/31/2013

DP-1032 (11/11/13)

Personal belongings such as cell phones, purses, and jackets will not be permitted on the unit at any time for the safety of all persons.

FMC Behavioral Health Services

1200 N Beaver St. (2nd Floor West Campus)
Flagstaff, AZ 86001
(928) 213 – 6300

ADULTS AND ADOLESCENTS
Daily Schedule

9:00 – 10:00 am	Phone and Visitation
2:00 – 3:00 pm	Phone hours
6:30 – 8:00 pm	Phone and Visitation
8:30 – 9:30 pm	Phone hours

At staff discretion

Appointment Date: _____ Counselor: _____ Time: _____

Please note that a Voluntary Admission to Flagstaff Medical Center Behavioral Health Services means that you understand the following:

- **You are being admitted to a locked inpatient psychiatric behavioral health facility.**
- **You agree to remain in the hospital unit until you and your psychiatrist mutually agree you are ready to leave. The average length of stay last 7 – 10 days.**
- **Your psychiatrist may recommend medications as part of your treatment.**
- **You agree to participate in our treatment program.**

Packing List for Behavioral Health Services

ITEMS TO BRING TO THE HOSPITAL:

No more than three changes of clothes (we have laundry facilities and provide all linens). All clothing must be in good repair. This should include:

- Comfortable pants, such as jeans or sweats without drawstrings
- Socks
- Sleepwear
- Underwear – Bras without underwires
- Slip-on shoes
- Basic toiletries such as shampoo, conditioner, lotion, comb or toothbrush & deodorant

PROHIBITED ITEMS

For health and safety reasons, all patients and patient belongings must be searched carefully.

- Weapons or tools
- Items with removable metal parts such as spiral notebooks, paper clips, thumbtacks, staples, pens with metal clips
- Items containing glass such as compacts, cosmetic bottles, vases
- Provocative sleepwear or clothing
- Clothing with lettering that refers to drugs, alcohol or has inappropriate messages
- Blade style razors
- Adolescent patients may not wear jewelry
- Nutritional supplements and vitamins, unless approved by doctor or pharmacist
- Products containing alcohol, such as mouthwash, skin care products or perfumes
- Brushes, combs or picks with metal parts
- Plastic bags and plastic wrap
- Large scrunchies (hair ties)
- Cords, ropes
- Shoes with pointed toes, heavy boots, steel-toed boots
- Money greater than \$25.00
- Food from outside places other than the hospital
- Compact discs, headphones, disc / tape players, cell phones & computers
- Baseball caps, beanies, bandanas
- Sunglasses

Any prohibited items or extra items will be inventoried and sent home with your family or will be stored.

Any exceptions to the items listed above will be at the discretion of the Treatment Team.

Visitors: Please leave all valuables, purses, backpacks and coats locked in your car.



Flagstaff Medical Center

Quest Program

**FLAGSTAFF MEDICAL CENTER BEHAVIORAL HEALTH
PATIENTS ARE OUR PURPOSE**

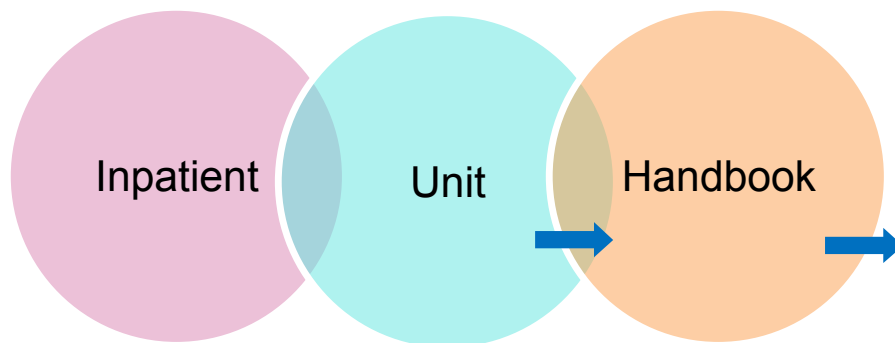
OUTLINE

**PLEASE READ ENTIRE QUEST
PACKET FIRST**

**THEN, COMPLETE THE
BEHAVIOR CONTRACT AND
QUEST QUIZ,**

**WHEN YOU ARE DONE WITH
THE QUIZ AND CONTRACT,**

GIVE TO STAFF



WELCOME

QUEST is the therapeutic adolescent program used at Flagstaff Medical Center Inpatient Behavioral Services. This program is designed to help you learn to trust, make choices, and work on self-control in a safe place. Three parts in this program help you develop important life skills and new behaviors and will be described fully in this packet. Staff are here to help you be successful. **You are responsible to know the information in this packet to complete the tasks and follow behavior guidelines while here.**

UNIT RULES

1. Cooperate with all medical care.
2. Eat meals with peers.
3. Treat yourself, others, all property with care. Do not harm or destroy anything or anyone, including yourself.
4. Use respectful language and tone of voice.
5. Follow physical, verbal, and emotional boundaries of others. Do not touch others.
6. Accept the results that happen from the choices you make.
7. Complete daily assignments.
8. Talk with staff and peers to get help with your work and goals.
9. Stay 5 feet from all exit doors.
10. Do not pass notes, share secrets, or get involved “gangs” or “cliques.” You may not share phone numbers or addresses with peers or staff to contact them.
11. Engage in groups, family, and individual sessions/therapies.
12. Wear your id band on wrist at all times.

13. Take a shower, brush teeth and hair, wash clothes and clean room daily or more if needed.
14. Keep point sheet with you at all times.
15. Stay in own room during self-reflection time. If you need something, go to the doorway of your room and ask staff.
16. No food or beverage (except water) outside of kitchen, unless approved by treatment team.
17. Return any items borrowed from staff prior to bedtime each night.
18. You will have privileges associated with the level/status you are on such as introductory level, self awareness level or working phase.

VISITATION/PHONE RULES

Visitation:

- Visits are limited to *immediate family* (parents/guardians and members of household age 17 and older) to foster better communication and prepare for discharge.
- Families who have children **under 17 need permission from staff prior to any visits/sessions for safety purposes.**
- Requests for other visitors will be considered when visitors will add healing benefit and the treatment team gives prior approval for visits.
- Visitors must disclose all materials brought to hospital for you, and staff will log the items on your property form if permitted on unit.
- Any visitors that are under the influence of alcohol or drugs will not be allowed on unit.
- Visits are limited to visiting times only, unless permission is given from staff to visit outside these times.
- All visits will occur in community area with staff presence for safety.

Phone:

- Parent/guardian must approve all callers and list on visitor log.
- Outgoing calls by you depend on which level you are in QUEST.
- Parents/guardians may call during phone hours to talk to you and anytime to talk with staff. They can call you at each phone time daily.
- All phone calls are limited to 10 minutes during phone hours only as you will be in therapy outside of these times. Special permission to call outside of these times must be approved by treatment team.
- Staff will supervise all calls, and will end calls if you or caller becomes abusive or destructive verbally.
- Violation of phone rules may result in loss of phone privileges.

Personal Property

Staff will inspect all property brought to unit for safety. Any items not accepted will be sent back with family or stored in locked area. The following items are permitted:

- 3 changes of clothes, sleepwear, shower/ hygiene supplies. Small personal effects such as photograph, blanket, pillow or stuffed animal is okay.
- Valuables will be sent home or stored in locked area on unit.
- Clothing with words/pictures of drugs, alcohol, violence, sex, gangs, or politics are not allowed. Any writing on clothing must be approved before worn on unit. Clothing must be worn properly with underwear/bra fully covered; no short shorts/skirts, tight or low-cut shirts, tank tops or half-shirts are allowed. Any items that are see-through or deemed revealing will be sent home or put in armoire for discharge.
- Stud jewelry (no dangles/hoops) in ear, nose, lip, tongue, and belly button is okay on unit. Socks must be worn at all times when outside of room.
- ✓ Items not allowed on unit:
 - Weapons, tools, sharp or pointed objects
 - Drugs, alcohol, cigarettes, lighters, matches
 - Glass objects, mirrors, sunglasses, hats, or makeup
 - Inhalants, flammable sprays or liquids
 - Hygiene products with alcohol
 - Plastic bags
 - Items with staples or paper clips, spiral bound notebooks
 - Cell phones, cameras, Ipods/MP3, tablets, CD players, laptops.
 - Personal medications
 - Any metal objects
 - Any other items treatment team deems is a safety risk
- ✓ Items not allowed in your room:
 - CD's
 - Mechanical/electrical equipment
 - Pens, pencils, art supplies, games
 - Food or drinks other than water
 - Any item deemed a safety risk or infection control risk by treatment team

Room Policy:

You are not allowed in any patient rooms, except your own. No peers are allowed in your room, except your roommate. Doors must remain open at all times, but can be closed with an opening of 12 inches for safety.

Room/Personal Searches:

Searches of your room, clothing, personal items, and person are a routine part of this program for safety. Any items found on a search that is not permitted (contraband) will result in consequences for this behavior.

Patients who are found to be withholding information about roommate or peers' contraband will also face consequences.



INTERVENTIONS FOR DISRUPTIVE/DIFFICULT BEHAVIORS

Self Time Out

When you feel unable to deal with your emotions in the unit, you may ask staff for a Self Time Out.

- a. You will be shown the time out area, walk there and stay there until approved to return to groups with staff assistance.
- b. Self Time Out will last until you and staff are both in agreement about your readiness to return to group and you have successfully completed the processing out form.

Staff Time Out

When a staff person sees disrespectful behaviors such as name-calling, profanity, threats, physical contact with peers, refusal to follow instruction, or other negative behaviors that block treatment, you may be asked to take a time out.

- a. You will be escorted to time out area by being asked to walk on own or staff will assist you.
- b. Staff will determine your readiness to return to group after you have calmed and demonstrate cooperation in successful completion of processing out form.

Restraint/Seclusion

Occurs when you threaten or engage in aggressive behaviors toward yourself, others, or destroy property AND are uncooperative with Staff Time Out. **If you are restrained or secluded, you will automatically be placed on Shelter described next.**

Shelter

You can be on this status if you engage in behaviors or gestures that are unsafe or threatening to yourself, others, or property. The treatment team works with you to re-evaluate your interactions on the unit separate from the group/peers for increased observation and support. Before you can move from this status, the treatment team will decide when you are ready based upon cooperative/safe behaviors, successful completion of journaling, complete restitution (make things right, apology) to group, and presentation of plan for improved participation and behaviors in group programming. Shelter lasts a minimum of 24 hours, but will continue past this time until you have completed all the work and self-control explained above. Shelter, officially, begins when you:

- a. Get into hospital garb.
- b. Turn in all personal belongings.

- c. Allow room/personal search.
- d. You are cooperative with staying in designated shelter area.
- e. You call your parent/guardian to tell them what happened and why you were placed on shelter status with staff accompaniment.
- f. You begin written assignments and demonstrate safe, cooperative behaviors.

While on shelter status, you will:

- a. Be separated from all peers/groups.
- b. You will be required to make 1 phone call daily to parent/guardian to tell them what and how you are doing with staff accompaniment.
- c. You will complete daily therapeutic assignments for all groups missed, as well as shelter journaling work.
- d. You will have restricted privileges such as no media, bedtime at 9pm, sleeping on floor with mat/mattress, no access to groups or meals with peers, no visits or family sessions.
- e. Staff will meet with you regularly throughout day and evening shifts for review and discuss progress.
- f. You will make final presentation of community of peers and staff to obtain final approval to return to introduction level from shelter status.

Community Shelter:

When there is a safety risk involving 2 or more patients on the unit, other patients are not helping the situation or it is unsafe for groups/sessions to be held, Community Shelter is started by the treatment team. Where each patient in unit is placed on shelter status and works through process described above in individual manner until treatment team determines it is safe to return to group status on introductory level.



Flagstaff Medical Center
Member of Northern Arizona Healthcare

Behavioral Health Services
1200 N. Beaver Street
Flagstaff, AZ 86001
928 213-6400

Parent(s)/Guardian(s):

This letter contains important information regarding your adolescent's treatment while on a locked psychiatric unit. Please be sure to read through it carefully and contact us with any questions.

Several professionals make up the Adolescent Treatment Team providing care of your teen. While we are all involved in treatment, your point of contact is the Adolescent Nurse. He or she can be reached at (928) 213 – 6300.

If you have not already done so, please schedule a family therapy session, unless instructed differently by our Intake Department. In most cases, we recommend that you be available for a face-to-face session as soon as possible. This is of great importance due to the typically short stay of an acute care hospitalization. Please know that Flagstaff Medical Center Behavioral Health places a high value on family involvement in care.

Please also expect to be contacted by a team member so that we may gather important information about your adolescent. This may be completed over the phone or at the time of the initial family session. A plan for your adolescent's treatment will be reviewed with you.

You are encouraged to read the Inpatient Adolescent Unit Handbook QUEST packet. By becoming familiar with the information in the QUEST packet, you can better understand the therapeutic goals and work that your adolescent is completing while hospitalized.

Please note that daily visiting and phone hours are listed below. Visitor's personal belongings such as cell phones, purses, and jackets will not be permitted on the unit, for the safety of all patients. Please plan ahead to leave such items at home or in your vehicle safely secured.

Visitation and Phone Hours

Daily

9:00 – 10:00 am

2:00 – 3:00 pm

6:30 – 8:00 pm

8:30 – 9:30 pm

And at staff discretion

Phone and Visitation

Phone hours

Phone and Visitation

Phone hours

Sincerely,
Adolescent Treatment Team
Behavioral Health Services