Alternative Consulting Enterprises, LLC
OUTPATIENT SERVICES

Name: _____ DOB: _____

SSN#: _____ Male: ☐ Female: ☐ Age: _____

Address: _____

Phone #: _____ Alternate Ph #: _____

Email address: _____

Names of Legal Guardians: _____Guardian Ph#:_____

Referral Source-Name/Ph #:_____

Emergency Contact- Name/ Ph#: _____

Name of Primary Care Physician/Ph#: _____

Name of School/ Ph#: _____

Primary Insurance: _____ Secondary Insurance: _____

Insurance ID: _____ Insurance ID: _____

Do you have an Advanced Directive? Yes: ☐ No: ☐

Presenting problems (Check all that apply):

Depression ☐	Anxiety ☐	Trauma ☐	Grief/Loss ☐
Psychosis ☐	OCD Symptoms ☐	Oppositional behaviors ☐	Attention/hyperactivity ☐
Sleep Disturbance ☐	Developmental delays ☐	Anger management ☐	Other:

List all known allergies and adverse reactions:

_____

_____

Do you have a Wellness Recovery Action Plan (WRAP Plan)? Yes ☐ No ☐

Special Accommodations (if any):

_____

_____

Signature of Client/ Legal Guardian & Date

Updated Dec 2020

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Patient Bill of Rights

According to the Pennsylvania code 5100.53 Bill of Rights for patients, all patients are to receive notice of his/her Bill of Rights. The following are the Bill of Rights as set forth in PA Code 5100.53:

1. You have the right to unrestricted and private communication inside and outside this facility including the following rights:
   a. To a peaceful assembly and to join with other patients to organize a body of or participate in patient government when patient government has been determined to be feasible by the facility.
   b. To be assisted by any advocate of your choice in the assertion of your rights and to see a lawyer in private at any time.
   c. To make complaints and to have your complaints heard and adjudicated promptly.
   d. To receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with your or others' treatment or welfare.
   e. To receive and send unopened letters and to have outgoing letters stamped and mailed. Incoming mail may be examined for good reason in your presence for contraband. Contraband means specific property which entails a threat to your health and welfare or to the hospital community.
   f. To have access to telephone designated for patient use.
2. You have the right to practice the religion of your choice or to abstain from religious practices.
3. You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you made and keep the proceeds from its sale.
4. You have the right to handle your personal affairs including making contracts, holding a driver's license or professional license, marrying, or obtaining a divorce and writing a will.
5. You have the right to participate in the development and review of your treatment plan.
6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish the treatment goals.
7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.
8. You have the right not to be subjected to any harsh or unusual treatment.
9. If you have been involuntarily committed in accordance with civil court proceedings, and you are not receiving treatment, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.
10. You have a right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with existing Federal wage and hour regulations.

By signing below, I acknowledge that I have read and understand the Patient Bill of Rights.

_____ _____
Signature of Client/ Legal Guardian Date

_____ _____
Signature of Witness Date

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Name: _____ DOB: _____

Consent for Behavioral Health Treatment

I voluntarily consent that I will participate in behavioral health treatment at Alternative Consulting Enterprises, LLC for myself or the identified person whom I am the Legal Guardian. I understand that services may be provided by licensed counselors, unlicensed counselors, psychologists and/or psychiatrists. Services may include interviews, assessments, psychotherapy, and medication management.

I understand that behavioral health treatment has both benefits and risks. Risks may include experiencing unwanted feelings or thoughts when discussing past or current life experiences. I understand that psychotherapy includes benefits such as improving quality of life and mental wellness.

I understand that the exchange of health records between medical providers is essential in providing coordination of care. I understand that ACE will work to coordinate care with my Primary Care physician on an on-going basis by requesting medical records at the onset of treatment and every year thereafter unless the appropriate Release of Information has been revoked or suspended.

I understand that I have a choice to participate in medication management in order to address my mental wellness. If I receive medication management services, I understand that I may experience side effects from medications, which I will immediately report to my psychiatrist.

By signing below, I acknowledge that I have read and understand the Consent for Behavioral Health Treatment.

_____ _____
Signature of Client/ Legal Guardian Date

_____ _____
Signature of Witness Date

Consent for Telepsychiatry

I voluntarily consent that I will participate in telepsychiatry which is a form of telemedicine that allows patients to access psychiatric care using videoconferencing. I understand that network and software security protocols shall be utilized to protect the confidentiality and integrity of the information shared.

I understand that the benefits include improved access and availability of psychiatric care. I understand that potential risks may include: insufficient information sharing from poor video or audio interference, failure of equipment may result in delays in medication evaluations, and the observation of client affect and other behavioral observations may be less accurate due to the nature of video conferencing.

I understanding that the laws that protect privacy and confidentiality of health information apply to Telepsychiatry. I understand that I have the right to withhold or withdrawal my consent at any time with a formal written request. I understand that while receiving medication management services, I may receive medication that may cause adverse side effects which I will immediately report to my psychiatrist.

By signing below, I acknowledge that I have read and understand the Consent for Telepsychiatry.

_____ _____
Signature of Client/ Legal Guardian Date

_____ _____
Signature of Witness Date

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Name: _____ DOB: _____

Client and Family Responsibilities

Cancellation of Appointments and Discharge:

- Twenty-four hour notice must be given when cancelling or rescheduling an appointment.
- Discharge of a client shall occur when the client's symptoms have been ameliorated and the client has agreed that there is no further medical necessity for treatment to continue.
- If the client is not "at risk," and he/she fails to attend three appointments without contact within a six month period, (or) the therapist has not had any contact with the client after 30 days, the client may be discharged. If the client is considered to be "at risk," the therapist will contact the case manager or family member to assist in setting up additional services.
- If the client is misusing or abusing medications which is prescribed by an ACE physician, he may be subject to immediate discharge.
- If the client has consistent mismanagement of medications or theft of his prescriptions, he may be subject to immediate discharge.
- If the client displays inappropriate behaviors when in the office which impedes on the therapeutic experience of others, the provider has the right to discharge.

Copays, Deductibles, Payment Plans:

- Copays and deductibles will be collected prior to services being rendered.
- Clients can be refused services if they are unable to pay for copays or deductibles at the time services are rendered.
- Payment plans will be available to those clients who have a balance that exceeds $80. Clients with balances less than $80 will be required to make payment in full prior to services being provided. Clients will be required to pay 20% of the balance (in addition to the copay, if applicable) at the time services are rendered.

Fees for services (Out-of-pocket):

Clients who would like to receive services but do not have active or in-network insurance may pay for services out of pocket using the following fee schedule:

Individual therapy with non-licensed clinician (1 hour) : $85
Individual therapy with licensed clinician (1 hour): $105
Medication check with psychiatrist (In-person): $75
Medication check with psychiatrist (telepsychiatry): $100
Psychiatric Evaluation: $175

Request for Medical Records:

- Clients may have access to his/her records when a request is provided in written form to the Executive Director. Access does not imply physical possession of the medical record but rather a review of the record with supervision from management as coordinated by the Executive Director.
- Access may be denied when it is determined that disclosure of the specific information will cause a substantial detriment to the client's treatment or when the disclosure of specific information will reveal the identity of persons or breach the confidentiality of other person who has provided information upon an agreement to maintain their confidentiality.
- Clients may have access to the appointment record, medication list, treatment plan, safety plan, HIPAA disclosure, and an authorization to release information without additional fees.

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- Multiple copies of documents may incur a charge of $0.50 per copy and may require processing of up to two weeks.
- Medical record requests shall be processed within 7-10 business days.

Social Security Disability Applications:

- Patients must be in treatment for a minimum of one year in order for an application to be reviewed by the psychiatrist.
- The treating psychiatrist reserves the right to deny applications in the event that the psychiatrist believes the patient is able to hold employment.
- It is recommended that patients who are seeking a more immediate results would consult with a Disability Lawyer or visit http://www.socialsecurityclaim.net/social-security-disability-berks-county-pennsylvania/ to gain additional information.

Client Grievance Procedure:

- All clients or family members may initiate a complaint orally or in writing to an ACE staff member. The complaint shall be presented as soon as possible to the Executive Director. All clients and family members are permitted to have a witness present when providing a complaint.
- The Executive Director shall investigate the complaint and obtain a resolution. A resolution will be provided in writing within 2-4 business days after the complaint has been filed. This document will be mailed to the client and filed in the medical record.
- At any time, clients are able to make a complaint directly to his/her insurance company. ACE will comply with any requests made by the insurance companies or legal governing agencies that may be involved in the grievance process.
- The client or representative may appeal the grievance decision within 10 days of the decision.
- Once the written appeal has been received, the Executive Director will meet with the treatment team to review the appeal. The treatment team will determine if an additional internal investigation is required. If immediate action is required, the treatment team may contact the insurance company's grievance department for resolution assistance.
- Appeals will not jeopardize the continued treatment of the client unless otherwise requested by the client or it is determined that a referral should be made due to the nature of the complaint.
- If an additional internal investigation occurs, the client will be provided with an updated resolution within 2-4 business days of the appeal. This document will be mailed to the client and filed in the medical record. If an outside investigation is conducted by an insurance company, ACE will cooperatively work with the insurance company to complete the appeal procedure.
- The second appeal may be requested by the client and the appeal procedure may be repeated. ACE will comply and make every effort to resolve the second appeal and cooperate with the insurance company

By signing below I have read, understand and agree to follow the above listed Client and Family Responsibilities.

_____ _____
Client/ Legal Guardian Signature Date

_____ _____
Witness Signature Date

Alternative Consulting Enterprises, LLC
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AUTHORIZATION FOR RELEASE OF RECORDS
PROTECTED HEALTH INFORMATION- PHI

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I authorize Alternative Consulting Enterprises, LLC (ACE), to obtain or disclose information from my medical record, which may include information about my psychiatric diagnosis, treatment, and mental health to ☐ and/or from ☐:

Name: _____ Phone:_____

Address: _____ Fax: _____

Purpose of Disclosure: _____ Coordination of Care: _____ Other: _____

Information to be released by ACE:

☐ Psychiatric Evaluation ☐ Treatment Plan ☐ Biopsychosocial Assessment

☐ Medication list ☐ Discharge Summary ☐ Attendance Record

Information to be sent to ACE:

☐ Most recent visit with provider ☐ Medical Records from Dates of service: _____

☐ Most recent lab results ☐ Other: _____

☐ IEP ☐ Behavior Reports ☐ Coordination Care/Communication

☐ Psychiatric Evaluation ☐ Treatment Plan ☐ Biopsychosocial Assessment

By signing below, I acknowledge that I have read and understand the following:

1. I understand that this authorization will expire one year from the date of the signature unless withdrawn.
2. A photocopy of this authorization shall be considered as the original.
3. I understand that I may revoke this authorization at any time by submitting a formal written request to ACE so that this authorization shall no longer be effective except to the extent action has already been taken upon it.
4. I understand that information disclosed or used pursuant to this authorization may be subject to re-disclosure but only in compliance with Federal privacy regulations and any State or Federal laws prohibiting the disclosure of PHI.
5. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of information is necessary for treatment.
6. I understand that I may obtain a copy of this form after it is signed by all parties.
7. I understand that I am authorizing the release of my records to initiate or continue treatment in order to sustain continuity of care.

_____ _____

Signature of Client/Guardian & Date Signature of Witness & Date

If the client is unable to provide a signature, two responsible parties must sign below to witness that the client understands that nature of the release and freely give his/her verbal consent as outlined above.

_____ _____

Signature of Witness #1 & Date Signature of Witness #2 & Date