LIGHTHOUSE CARE CENTER OF AUGUSTA

Residential Care Unit

Welcome to Lighthouse Care Center of Augusta. We are proud to serve your child and family in this time of need. Please review this document for quick reference of a few key points.

Visiting hours:

Saturday and Sunday
2:00PM-4:00PM

Phone calls will be coordinated with assigned therapist during sessions.

Children under the age of 12 will not be permitted during visiting hours and are not permitted to be left unattended in the lobby. All visitors must be authorized prior to visitation on your child's consent documents. Visitors must present with photo ID and will be required to leave all personal items at reception. Only 2 visitors at a time.

Recommendations of Personal Belongings:

Please label all personal items with your Child's first name and last initial

- 5 days worth of comfortable clothing (5 pants/5 tops)
- 7 pairs of underwear and socks (2-3 sports bras, no underwire)
- Two pairs of slip on shoes (no laces are permitted)
- 2 sets of appropriate bedtime clothing (not see through, tight or revealing)
- A jacket or sweater with no hoods or strings
- One swimsuit (during summer months; must be conservative)

The facility and staff will not be responsible for any lost or damaged belongings as a result of excessive items being left, patient trading clothing or patient behavior that results in personal damage of property.

In order to provide the best possible care of your child we request that **the listed items are to be left home or with a trusted guardian:**

- Outside food or drink
- Money
- Clothing items that are too tight, revealing or advertise substance abuse
- Underwire bras, tank tops or thong underwear
- Glass items of any kind
- Makeup, perfume or cologne of any kind
- Headphones, cell phones, electronics of any kind
- Pens and spiral notebooks
- Tobacco products and electronic cigarettes
- Flat irons, hair dryers, curling irons or metal combs
- Boots, shoes with laces

3100 Perimeter PKWY, Augusta, GA. 30909 Phone: 706-651-0005

IGHTHOUSE
CARE CENTER OF AUGUSTA

Patient Label

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

REGISTRATION FORM

Patient's Name_____ Telephone Number_____

Mailing Address _____ Cell Number_____

City/State/Zip _____ Patient's S.S.N._____

DOB:_____ AGE:_____ Gender: F M Marital Status _____

Guardian/ Person Completing Form

Name_____

Address_____

City/State/Zip_____

S.S.N./DOB_____

Employer_____

Home/Work Phone#_____

Relationship to Patient_____

Parent/Relative

Name_____

Address_____

City/State/Zip_____

S.S.N./DOB_____

Employer_____

Home/Work Phone# _____

Relationship to Patient_____

Insurance Information (Provide copy of Card front and back)

Primary Insurance : _____

Policy Holder's Name and Relationship

_____

Member ID:_____

Phone #_____

Secondary Insurance: _____

Policy Holder's Name and Relationship

_____

Member ID: _____

Phone # _____

How did you hear about us? (please list name or agency)

_____

Circle Presenting Problem (e.g., depression, anxiety, substance abuse, etc)

Depression	Aggression	Suicidal Thoughts	Trouble Concentrating	Confusion
Anxiety	Low Energy	Medication Issues	Homicidal Thoughts	Sadness
Alcohol Dependency	High Energy	Hearing Voices	Trouble Sleeping	Anger
Drug Dependency	Family Issues	Isolation	Hallucinations	Self-Injurious Behavior
Strange Thoughts				Change in Personality

Are there any medical conditions that we need to be immediately aware of? [ ]Yes [ ]No If yes, explain.

_____

_____

I certify that the above information is true and correct. I authorize the administrator of the above named plan(s) to release information to my insurance carrier regarding health care benefits to which I may be entitled. I understand that the purpose of the release of information is to assure appropriate coordination of benefits of all plans. This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand a photocopy of this authorization shall be valid as the original.

_____ _____

Signature of Person Completing Registration Form **Parent/Legal Guardian Signature**

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

COMMUNICABLE DISEASE and BERLIN QUESTIONNAIRE

This brief questionnaire is a screening tool to help identify possible communicable diseases.

Do you currently have or have you ever had:

	Measles	❑NO	❑YES - When?
	Mumps	❑NO	❑YES - When?
	Rubella	❑NO	❑YES - When?
	Chicken Pox	❑NO	❑YES - When?
	Hepatitis	❑NO	❑YES - When?
	HIV	❑NO	❑YES - When?
	Tuberculosis	❑NO	❑YES - When?
	Lice	❑NO	❑YES - When?
	Scabies	❑NO	❑YES - When?
	Other	❑NO	❑YES - When?

Are you under the care of a physician or taking medication for a communicable disease? ❑NO ❑YES

If yes, Explain:

Have you had recent contact with someone with any of the above illnesses? ❑NO ❑YES

If yes, Explain:

Have you ever been tested for Tuberculosis? ❑NO ❑YES

If yes, 4b. Explain:

4c. Have you ever tested positive for TB?

If yes, 1. Did you have a chest x-ray?

2. Were you treated?

Please check YES or NO to ALL symptoms as they apply to you currently:

	Productive Cough (3 or more weeks)	❑NO	❑YES
	Persistent Weight Loss without Dieting	❑NO	❑YES
	Persistent Low Grade Fever	❑NO	❑YES
	Night Sweats	❑NO	❑YES
	Loss of Appetite	❑NO	❑YES
	Swollen Glands (Usually in the Neck)	❑NO	❑YES
	Recurrent Kidney Infections	❑NO	❑YES
	Shortness of Breath	❑NO	❑YES
	Chest Pain	❑NO	❑YES
	Productive Cough (3 or more weeks)	❑NO	❑YES

Complete the Following about the Patient:

Height: Weight: Age: Sex: Do you snore? ❑YES ❑NO ❑ Don't Know **If you snore:**

Your snoring is? ❑slightly louder than breathing ❑as loud as talking ❑ louder than talking ❑ very loud. Can be heard in adjacent rooms.

How often do you snore? ❑ nearly every day ❑3-4 times a week ❑ 1-2 times a week ❑ 1-2 times a month ❑ never or nearly never

Has your snoring ever bothered other people? ❑YES ❑NO

Has anyone ever noticed that you quit breathing in your sleep?
❑ nearly every day ❑3-4 times a week ❑ 1-2 times a week ❑ 1-2 times a month ❑ never or nearly never

How often do you feel tired or fatigued after your sleep? ❑ nearly every day ❑3-4 times a week ❑ 1-2 times a week ❑ 1-2 times a month ❑ never or nea

During your wake time, do you feel tired, fatigued or not up to par? ❑ nearly every day ❑3-4 times a week ❑ 1-2 times a week ❑1-2 times a month ❑ne nearly never

Have you ever nodded off or fallen asleep while driving a vehicle? ❑YES ❑NO
If yes, how often? ❑ nearly every day ❑3-4 times a week ❑ 1-2 times a week ❑ 1-2 times a month ❑ never or nearly never

Do you have high blood pressure? ❑YES ❑NO ❑ Don't Know

Sign Here	
Signature of Parent/Legal Guardian	**Date**

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

INDIVIDUAL DE-ESCALATION PLAN

This plan will allow you to suggest calming strategies in advance of a crisis. It will allow you to list things that are helpful when you are under stress or are upset. It will also allow you to identify things that make you angry. This information is intended to be helpful. It will help staff better understand you.

School Time Calming Strategies: It is helpful for us to be aware of things that help you feel better when you're having a hard time during school/group. Indicate the activities that have worked or that you believe would be helpful. You can check as many activities as you like.

☐ Take deep breaths	☐ Ignore negativity	☐ Count to 10
☐ Positive self talk	☐ Talk to staff	☐ Muscle relaxation technique
☐ Stop & think	☐ Take 5 minute time out	☐ Other (specify below)

After School Calming Strategies (Free time)

☐ Listen to music	☐ Journal	☐ Talk with staff
☐ Read	☐ Artwork	☐ Talk with a positive peer
☐ Be left alone	☐ Exercise	☐ Walk in appropriate area (Pace)
☐ Hug a stuffed animal	☐ Other (specify below)	

Preferences and alternatives suggested by parent/guardian during orientation process. Mark *NA* if parent/guardian not present: _____

Triggers that can lead to crisis: What are some things that make you angry or upset?

☐ Being touched	☐ People in uniform	☐ Being called names/made fun of
☐ Yelling	☐ Loud Noises	☐ Physical force
☐ Being Isolated	☐ Being restrained	☐ Being Threatened
☐ Someone lying about my behavior	☐ Other (specify below)	

Gender Preference: Do you have a preference regarding the gender of staff assigned to you during a time when you are upset or angry? ☐ Female ☐ Male ☐ No preference

Signals of Distress: Please describe your warning signals. Based on what you know about yourself, what things happen when you start to get upset?

☐ Sweat	☐ Cry	☐ Rapid breathing
☐ Try to hurt yourself	☐ Try to hurt others	☐ Try to damage property
☐ Pacing	☐ Try to run away	☐ Cursing
☐ Threatening	☐ Being rude	☐ Ball up fist
☐ Clenched teeth	☐ Throwing objects	☐ Other (specify below)

Extreme emergencies: Physical restraint may be used as a last resort. Is there anything you find helpful when you are in crisis that could prevent this intervention being used?

_____

_____ _____

Patient/Guardian Signature **Date** **Lighthouse Staff Signature** **Date**

Date

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ **Over 18 years of age**

☐ **Under 18 years of age**

☐ **Emancipated minor child**

☐ **Over 18 but still dependent**

ACKNOWLEDGEMENT

I acknowledge that I have received the Hospital's Notice or Privacy Practices.

Signature of Patient	Date

Sign Here

Signature of Guardian	Date
Signature of Lighthouse Staff and Title	Date

Patient/Guardian is unable to sign this receipt because:

RECEIPT OF ENSURING HOME SAFETY RECOMMENDATIONS

ACKNOWLEDGEMENT

I acknowledge that I have received the Hospital's Lethal Means Matter Recommendations.

Signature of Patient	Date

Sign Here

Signature of Guardian	Date
Signature of Lighthouse Staff and Title	Date

Patient/Guardian is unable to sign this receipt because:

ENSURING HOME SAFETY

RECOMMENDATIONS FOR FAMILIES

If you are concerned that a member of your household may be suicidal, there are steps you should take to restrict access to dangerous weapons, lethal medications and other harmful substances at home.

IMPORTANT NUMBERS

LIGHTHOUSE CARE CENTER OF AUGUSTA: 706-651-0005

GA CRISIS & ACCESS LINE: 800-715-4425

POISON CONTROL: 800-222-1222

RICHMOND COUNTY SHERIFF'S OFFICE: 706-821-1110

IN CASE OF ANY TYPE OF EMERGENCY, PLEASE CALL 911

COMMON MEANS OF SUICIDE

Fire Arms	Electrocution & Drowning	Hanging & Strangulation
Firearms are the most lethal among suicide methods, so it is very important that you remove them or, at the very least, lock up and secure them until things improve at home.	Monitor bathroom/pool use of persons who are suicidal to ensure they do not try to drown themselves. Remove any plugged in electrical devices that can be pulled into a pool or bathtub.	Belts, shoelaces, strings, ropes and other objects can easily be used for hanging. Decrease the risk of suicide by hanging or strangulation by removing or locking up all hazardous items if possible.
Sharp Objects	**Alcohol**	**Gas & Carbon Monoxide Poisoning**
Lock up sharp objects such as knives and razor blades and objects that can be broken into sharp pieces, such as glass and metal, whenever possible	Alcohol increases the chance that a person will make an unwise choice, like attempting suicide, and heightens the lethality of a drug overdose. Keep only small quantities of alcohol at home.	Exposure to car exhaust fumes or emissions from gas appliances, in enclosed "non-ventilated" areas, can be fatal. CO is a colorless, odorless & tasteless substance.

MEDICATIONS (INCLUDING PRESCRIPTIONS, OTC MEDS, VITAMINS AND HERBAL SUPPLEMENTS):

Do not keep lethal doses at home. Your doctor, pharmacist or the poison control center (1-800-222-1222) can help you determine safe quantities of medicines you need to keep on hand. Be particularly proactive by keeping prescription medications (such as narcotics and benzodiazepines) under lock and key because of their lethality and potential for abuse. See reverse side for information on how to dispose of excess medications safely.

www.MEANSMATTER.com

Guardian's Copy Please take home for your records.

ABOUT MEDICATIONS (Adapted from FDA)

Medicines play an important role in treating many conditions and diseases but when they are no longer needed, they should be properly discarded to prevent harm to others. Disposal options and special instructions to follow when discarding expired, unwanted or unused medicines are listed below:

Medicine Take-Back Programs

Medicine take-back programs are a good way to remove expired, unwanted or unused medicines from home and reduce the chance that others may accidentally or intentionally use them. Contact your city or county government's household trash and recycling service to see if there is a medicine take-back program in your community and learn about any special rules regarding which medicines are eligible. You can also talk to your pharmacist to see if they know of other medicine disposal programs in your area.

Disposal in Household Trash

If no medicine take-back program is available in your area, you can follow these simple steps to dispose of most medicines in the household trash:

- Mix medicines (do NOT crush tablets or capsules) with an unpalatable substance such as kitty litter or used coffee grounds;
- Place the mixture in a container such as a sealed plastic bag; and
- Throw the container in your household trash

Flushing of Certain Medicines

Certain medicines may be especially harmful or potentially fatal in a single dose if used by someone other than the person for whom they were prescribed. For this reason, a few medicines have specific disposal instructions that indicate they should be flushed down the sink or toilet when they are no longer needed and when they cannot be discarded through a drug take-back program. When these medications are discarded in the sink or toilet they cannot be accidently used by children, pets or anyone else. You may have received disposal directions for these medicines with your prescription. If you did not receive disposal instructions with your prescription, you can *call the FDA at 1-888-INFO-FDA (1-888-463-6332).*

ABOUT FIREARMS (Adapted from Maine Youth Suicide Prevention)

A lethal weapon accessed by a person in despair can end a life in an instant! Firearms are used in five out of ten suicides in the U.S. Removing lethal means from a vulnerable person, especially a minor, can save a life. It is like keeping the car keys away from a person who consumed too much alcohol.

Who Can Help Store or Dispose of a Firearm?

Some law enforcement departments (not all) will take firearms. Some offer temporary storage, permanent disposal options or both.

What if Law Enforcement Is Not an Option?

- **Temporarily store** the firearm at the home of a trusted relative or friend. Be sure the person at risk cannot obtain the firearm before or after it is removed. NOTE: Not all people can hold the guns for you.
- **Lock** the unloaded firearm in a gun safe or tamper-proof storage box with ammunition locked in a separate location. (BETTER YET, do not keep ammunition at home). Trigger locks are sold in sporting goods stores and where firearms are sold. Some police departments offer free locks. Be sure the keys and storage box combinations are kept away from the person at risk. Remember: This does not guarantee safety. Minors are resourceful and usually figure out where their parents hide objects.
- **Do not** store firearms in a bank safe deposit box. Most states have laws that prohibit carrying a weapon into federally insured buildings such as banks.
- **Sell** the firearm following the appropriate legal guidelines.

Guardian's Copy Please take home for your records.

Respecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determinec that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do no use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

Guardian's Copy Please take home for your records.

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call **1-877-696-6775.**

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1

Guardian's Copy Please take home for your records.

LIGHTHOUSE CARE CENTER OF AUGUSTA

STATEMENT OF RESIDENT RIGHTS

As a resident of Lighthouse Care Center seeking treatment you are entitled to the following rights:

- The right to receive services no matter what you look like or what you believe in. (To receive services regardless of race, sex, creed, or color.)
- To have people treat you appropriately and with respect. (To receive considerate and respectful care.)
- To know that your records are private and that the law says that no one can see them without permission unless authorized or mandated by law. (To know that your records are protected under Federal and State Confidentiality Regulations which prohibit unauthorized disclosure of information?)
- To have privacy as much as possible. (To receive privacy whenever it is indicated.)
- To have treatment and service made especially for you, based on your needs, (To receive individual evaluations and individual treatment based upon your needs and goals.)
- To have someone explain your treatment to you. (To know the rationale of all services provided to you.)
- To know who the people are that are helping you and what qualifies them to do so. You also have the right to know who is most responsible for your care. (To know the identity and professional status of individuals providing service and to know which professional is primarily responsible for your care.)
- To say no to treatment as long as the law says it is OK for you to do so. (To refuse treatment to the extent permitted by law.)
- To look at your records and to get feedback about your progress. (To review your records upon request and to receive current information concerning diagnosis, treatment, and prognosis.)
- To be given a quiet, safe place when you feel like you need one. (To be placed in protective privacy when necessary for safety.)
- To expect a safe place to live and play while at Lighthouse Care Center. (To expect reasonable safety as far as the Lighthouse Care Center practices and environment are concerned.)
- To be involved in creating special programs which will be used in your treatment and general health care. (To participate voluntarily in research, special programs, or unusual medication protocols and to participate to the degree possible in decisions involving your health care.)
- To leave Lighthouse Care Center and not take part in services without giving up the chance to come back at a later time. (To withdraw from services of Lighthouse Care Center without disqualifying you from consideration for admission at a later time.)
- To be told about moving to another place, discharge, or other treatment services. (To be given information relative to transfer, discharge, or continuing care.)
- To say no to treatment that you feel may hurt you, if the law says you can. (To refuse treatment considered detrimental to your welfare within the limits of the law.)
- To make a complaint if you think any of these rights have been denied or not fully explained to you. (To file a grievance, if you think any of these rights have been restricted or denied.)
- To have medical treatment when it is necessary. (To receive prompt medical treatment.)
- To be allowed to do schoolwork. (To have access to an appropriate education.)
- To live in a dorm that is clean and safe. (To live in a safe, clean and healthy environment.)
- To have a place in your room to display your personal items.
- To have clothing that is safe, appropriate, durable, suitable to the season, and similar to that worn by persons outside of the facility.
- To daily physical activity and recreation.
- To be protected from harm, abuse, neglect, or exploitation. (To be free of physical, emotional or sexual harassment or abuse and corporal punishment; goods and services will not be sold to or purchased from you except through established Lighthouse Care Center policies.)
- Residents will not be subjected to unnecessary physical restraints. (Behavioral interventions or Special Procedures will not be used as coercive measures for convenience of staff or as discipline)
- To not be removed from your community without good reason.
- To vote, if permitted by law.
- To practice your own religion and spirituality.
- To be able to speak to your outside agency workers. (To have unimpeded communication with your stated agency representative and other professional persons or agencies involved in your case.)
- To have visitors, mail, phone calls, or other forms of communication except when contraindicated for therapeutic effectiveness.
- To social interactions and to participate in community activities. (To participate in social interactions with others, including other residents and non-residents, unless restricted in writing in the record.)
- To dignity, privacy and humane care in the provision of personal health, hygiene and grooming care, keep and use personal clothing and possessions and have access to individual storage space for safekeeping of personal belongings.
- To be free from the threat or fear of unwarranted suspension or expulsion from the facility.
- To request an in-house review of your care, treatment, and service plan or, at your own expense, you can request the opinion of a consultant (If you disagree with your care or your future plan, you can ask for someone else at Lighthouse Care Center to review your care or plan. If you would rather get a second opinion from someone outside of new Hope, you are allowed to do so but you will have to pay for it yourself).
- To have you and/or your family or guardian informed about the outcomes of care, treatment, or services that have been provided, including unanticipated outcomes (this will be via a phone call or a letter).
- If you feel like your rights have been denied, you can make a complaint. If you want to make a complaint, you have to follow the resident grievance procedure. If you don't understand this, you can ask your therapist, staff or a teacher to explain what you need to do. You will not get into trouble for making a complaint or honestly reporting problems to staff.

- If you feel that your rights have been violated, you may contact the following:

- Lighthouse Care Center Patient Advocate-

  Telephone (706) 651-0005

GUARDIANS COPY PLEASE TAKE HOME FOR YOUR RECORDS

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

CONSENT FOR TREATMENT AND ADMISSION

Consent for Treatment	**Accept:_____**	**Decline:_____**

The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, as to the results of any services provided to the patient, including but not limited to therapy, treatment, tests or procedures, while admitted to LCCA. The undersigned further understands that, unless otherwise disclosed, LCCA does not employ physicians and that the patient's admitting physician(s) and any other physician who may consult or provide services to the patient during this admission are not employed by and are not agents of LCCA, but are independent physicians who exercise their judgment in the services they render to their patients.

The undersigned authorizes LCCA to search the personal belongings of the patient when it is believed that the patient may be in possession of items which may be dangerous to his/her health or the health of others. If items are found, it is understood that they will be maintained in a secure place and returned to the patient upon discharge unless otherwise indicated by the attending physician.

The undersigned consents to having his/her photograph taken for the purpose of identification. Photograph(s) may be permanently retained in patient's medical record. The undersigned consents to be videotaped for the purposes of patient safety. Video is digital and is reviewed on an "as needed" basis. Video is not kept as part of the patient's medical record.

The undersigned releases LCCA from any liability for the loss or damage of personal property and money kept in the patient's room during his/her hospitalization. Furthermore, it is understood and agreed that LCCA shall not be liable for loss or damage to any money, personal valuables, or other articles unless deposited with the cashier for safe keeping.

Consent for Admission	**Accept:_____**	**Decline:_____**

The undersigned authorizes LIGHTHOUSE CARE CENTER OF AUGUSTA (LCCA), its staff, and attending physicians to render to the patient all customary care, therapy, treatment, current medications, tests, and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is given for any diagnostic procedures, medical treatment, recreational activities and therapy, and other treatment ordered by LCCA and/or attending physicians including, but not limited to, services provided by other Healthcare Professionals to the patient.

The undersigned affirms he/she has retained no other medications on his/her person and agrees that all medications must be dispensed by LCCA pharmacy or by a registered nurse while he/she is a patient of LCCA.

The undersigned agrees that LCCA will not be responsible for the safety or care of the patient if the patient leaves the premises and will indemnify LCCA from any loss or injury which may occur as a result of leaving against medical advice.

The undersigned understands that the use of reasonable restraint and/or confinement may be necessary if severity of symptoms or behaviors warrant, in order to protect the patient from harming self or others, or destroying property. Should such restraint and/or confinement become necessary during the patient's admission, we understand that LCCA, its staff, physicians, or other mental health professionals are not liable for injuries that result from restraint and/or confinement that is administered in accordance with the policies and procedures of LCCA.

The undersigned acknowledges that the patient is under control of attending physician(s) and LCCA is not liable for any act or omission in following the instructions of said physicians. The undersigned recognizes that certain healthcare professionals furnishing services to the patient (including, but limited to: psychiatrists and/or licensed social workers) may be independent contractors and not employees or agents of LCCA. **The undersigned further recognizes that the patient may be billed separately by their attending physicians and/or other healthcare professionals for services provided.**

IGHTHOUSE
CARE CENTER OF AUGUSTA

Patient Label

Emergency Medical Care: **Accept:_____** **Decline:_____**

If a physician's judgment indicates that a patient is in need of emergency medical care, I understand that every reasonable effort will be made to notify the parent or legal guardian prior to any treatment and/or transfer of the patient to another facility. However, if the emergency is life threatening and/or the parent/legal guardian cannot be reached by telephone; I understand that transfer to another facility may be necessary to render the medical emergency care needed.

Use of Photograph and Surveillance Equipment: **Accept:_____** **Decline:_____**

The undersigned consents to the taking of a photograph(s) for the purpose of identification. The photographs may be permanently retained in the patient's medical record. In addition, it is understood that there is use of surveillance equipment for monitoring to provide added security within the hospital. The undersigned also understands that the patient's privacy will be maintained within the use of this material. Video Conferencing technology may be used to facilitate and improve treatment.

Patient Rights and Responsibilities: **Accept:_____** **Decline:_____**

The undersigned affirms he/she has received a patient/parent handbook which has listed both the patient rights and responsibilities, that these rights have been explained and that they understand these rights and responsibilities. In addition, the undersigned agrees to all terms and conditions identified in the handbook. I have been informed that LCCA has a Patient Advocate whom I may contact if I have a grievance or complaint. A copy of this process, included in the handbook has been provided to me.

Family Involvement: **Accept:_____** **Decline:_____**

I, the parent/guardian agree to participate regularly in visitation, family therapy and/or multi-family sessions during the patient's stay at LCCA. I understand that failure to participate in any of these areas may necessitate reevaluation of the appropriateness of continued inpatient treatment at this hospital. I have been informed that payer sources (insurance or Medicaid) manage care organizations and other reviewing parties may require such participation as a criteria for continued stay for the patient at this facility.

Conditions for Discharge: **Accept:_____** **Decline:_____**

The undersigned understands that it is the policy of LCCA to attempt to provide a structured therapy regimen with effective quality treatment. If the treatment regimen is not completed prior to the exhaustion of the patient's health insurance benefits, the undersigned agrees to be liable for any charges incurred which are not paid by insurance in addition to the deductible and/or co-payment liability. It is not LCCA policy to discharge or transfer patients or end treatment regimens simply because insurance benefits have been exhausted. LCCA must be given notice of two full business days prior to discharging patients from the Residential Treatment Program.

Right to Request Discharge **Acknowledge_____**

The undersigned understands that he/she may ask for discharge at any time. The patient may not ask for discharge if they are under age 18 and the patient's parent or guardian signed them into the hospital. The request for discharge must be submitted to the RN in writing. I understand that a physician is not staffed on the premises 24 hours a day, but a physician is on call and may be reached 24 hours a day by hospital staff. I understand that if I am requesting discharge from this facility against Medical Advice (AMA) a, psychiatric assessment must be completed by a psychiatrist before discharge. This assessment will be completed as soon as feasible but not to exceed 72 hours. The physicians at LCCA are independent practionioners. The undersigned further recognizes that the patient may be billed separately by their physician and /or other health care professionals for their services provided.

LIGHTHOUSE CARE CENTER OF AUGUSTA

Patient Label

Consent to Inspection:	**Accept:_____**	**Decline:_____**
My doctor and/or LCCA through its employees, may require that my room, my possessions, and my person may be inspected from time to time without notice to ensure that articles and chemical substances which they consider dangerous to others and me are not in my possession or available to me or others. I give my consent to make such inspections and to remove any such articles and substances found. I unconditionally, waive any and all claims that I may have as a result of such inspections and I release my doctor and the Hospital and its employees from any and all liability that may arise as a result thereof.		

Teaching Institution:	**Accept:_____**	**Decline:_____**
I acknowledge that LCCA sometimes functions as a clinical teaching site for various clinical professions. I understand that these clinicians in training may participate in various aspects of my case.		

LCCA Patient and Parent/Guardian Handbook	**I acknowledged and understand the following _____**
I understand that upon admission to Lighthouse Care Center of Augusta patient will be provided a handbook. I am aware that this handbook is also made available for all Lighthouse Care Center employees. I understand that I will need to contact the patient's assigned Therapist/Case Manager for any specific details regarding his/her treatment while at LCCA. I understand that a copy of the handbook may be provided to me. Also, I have been informed and I am aware that a copy of the resident's rights is included within this handbook **.Patient Rights Advocate can be reached at (706)651-0005. I have been given a copy of the resident's rights as part of the consent packet _____.**	

Visitors	**I acknowledge and understand the following _____**
I am aware that Lighthouse Care Center of Augusta allows visitors to tour the facility and campus. I understand that this may mean that this child is seen by the visitor. Visitors are usually from a clinical background (medical staff or placing agency personnel) or guardians of potential patients. All visitors will be required to sign a Confidentiality Agreement before they are allowing in.	

Personal Property and Items/ Destruction of Property:	**Accept:_____**	**Decline:_____**
To avoid loss or damage, patients are encouraged not to keep personal items of value at LCCA. I understand that LCCA will provide safekeeping for my money and valuables. If I do not want to deposit my valuables for safekeeping, LCCA will not be responsible for any losses which may occur during my hospitalization. If items are forgotten, patients have thirty (30) days from discharge to retrieve these items before they are removed from LCCA. Personal clothing will be initialed with permanent marker in order to identify belongings. If you do not want items marked please do not send them with the patient. Patients are responsible for any damage to or destruction of LCCA property, or property belonging to others which may be located at LCCA. The undersigned agrees to accept liability for, and reimburse LCCA or other owners of property which the patient may damage or destroy.		

LIGHTHOUSE CARE CENTER OF AUGUSTA

Patient Label

Privacy Practices/Release of Information: **Accept:_____** **Decline:_____**

The undersigned authorizes LCCA to release all patient information, including but not limited to information regarding diagnosis and treatment while at LCCA, to any insurance company, or representatives providing coverage for this admission, or to any LCCA representative including, but not limited to LCCA employees, attending physicians, other healthcare professionals or organizations. This information may not be released to any other person or entity unless the undersigned so authorizes. In addition, the undersigned acknowledges that such disclosure shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released.

The undersigned further authorizes LCCA to release information for the purposes of obtaining pre-authorization for treatment and concurrent review and to release that information to medical review agencies, and/or payers providing coverage or having responsibility for this admission. The undersigned authorizes LCCA to release patient information regarding diagnosis and treatment to other healthcare providers who will be involved with ongoing care in accordance with the discharge plan. For all Value Options/Tricare and Wellcare/Magellan consumers, I authorize family session information and psychotherapy notes to be released to the insurance company upon request from that company.

The undersigned may request to receive a copy of this authorization for release of information and may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. The undersigned acknowledges that this authorization shall be valid until all payers' liability is resolved for this admission.

Applicability to Other Providers: **I acknowledge and understand the following _____**

The undersigned agrees in the event that other healthcare professional providers, including but not limited to other hospitals, furnish services to the patient while at LCCA ; the consent, assignments, guarantees, and release herein above set out shall apply to such other providers and services.

Financial Agreement: **I acknowledge and understand the following _____**

I acknowledge and understand that I have the following responsibility: I am responsible for all unpaid charges not covered by Insurance/Medicaid either for Medical Necessity or for uninsured services provided including co-pay, deductibles or balances as a result of loss of eligibility on the day of the denial, billable at the current negotiated rate at any point during the stay, including admissions.

I acknowledge and understand that as the authorized representative for the patient, I have the following responsibility: I am responsible for all unpaid charges not covered by Insurance/Medicaid either for Medical Necessity or for uninsured services provided including co-pay, deductibles or balances as a result of loss of eligibility on the day of the denial, billable at the current negotiated rate at any point during the stay, including admissions.

Financial Agreement:

I also acknowledge and give LCCA my permission to run a credit report through Equifax to determine collectability. This is a Confidential Report and will not affect your credit score.

Signature_____ **Date**_____

LIGHTHOUSE
CARE CENTER OF AUGUSTA

Patient Label

Assignment of Insurance Benefits: **Accept:_____ Decline:_____**

I assign any and all insurance benefits payable to me to LCCA. I understand that I am responsible for payment for services rendered at the Hospital including excluded services from my insurance either because the plan deems such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or preexisting conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney or collection expenses. I give permission to my insurance provider(s), including Medicare and Medicaid, to directly pay LCCA for my care instead of paying me. I understand that I am responsible for any health insurance deductibles and co- insurance and non-covered services. I further assign my rights to LCCA to, and hereby appoint LCCA as my personal representative, to (i) submit claims for payment for services and treatment rendered to me to payers, including but not limited to Medicare and Medicaid, and further assign my rights to/for payment for services and treatment rendered to me, and (ii) appeal from any and all denials of coverage, without limitation, to LCCA._____ _____

Primary Insurance Company **Secondary Insurance Company**

Fall Risk: **I acknowledge and understand the following _____**

It is our practice at Lighthouse to ensure we do everything we can to keep our patients safe. Interventions reducing risk of injury or harm are sometimes necessary in order to make this possible. Upon admit, patients are assessed by an RN to see if he/she is a fall risk. If that assessment reveals the patient is a fall risk, the staff will follow the Lighthouse Fall Prevention policy and any or all of the interventions as directed by the physician and nursing staff in order to keep the patient safe.

Consent for Follow-Up Contact **Accept:_____ Decline:_____**

The undersigned consents for LCCA staff members, other health care professionals, or their representatives contacting a family member by telephone in approximately one month to one year. LCCA makes periodic contact with those who have used its services, using the information to improve its services to patients and to make sure that LCCA is addressing patients' needs. Specific responses are not disclosed; only summary information is assembled.

Consent for Therapeutic Trial Visits/Field Trips/Activities **Accept:_____ Decline:_____**

The undersigned hereby acknowledges that the patient's attending physician may include activities or field trips away from the facility grounds as a part of treatment, and that the attending physician may at times allow the patient therapeutic trial visits away from the facility. In consideration of the value to the patient of such treatment, the undersigned hereby: (1) consent to the patient's participation in field trips, activities, and therapeutic trips, visits; (2) release LCCA , its employees, and its agents from all liability for any injury to the patient caused by any act or omission on their part in the course of such field trips, activities, and leaves; and (3) agree to indemnify and hold harmless LCCA and its medical staff, employees, and agents from all claims, costs and losses incurred as a result of any act of the patient while on such field trips, activities, and leaves. I give my permission for this child to participate in on and off-campus activities, including necessary transportation with LCCA staff, approved by Lighthouse Care Center. These activities may include but are not limited to swimming, roller/ice skating, putt-putt golf, movies, as well as day trips to amusement parks, and local festivals, etc. Activities will only include day trips.

LIGHTHOUSE CARE CENTER OF AUGUSTA

Patient Label

Transportation and Medical and Personal Needs Responsibility **Accept:_____** **Decline:_____**

I agree and understand that upon admission to Lighthouse Care Center of Augusta (LCCA) that I am responsible for the following:

- Additional clothing articles needed by my child / resident, and if necessary any special hygiene/over the counter required items.
- If my child needs emergency surgery, I will be responsible for signing the surgical consent from or have the placing agency representative present to sign these forms.
- Transportation to and from pre-placement interviews and /or pre-placement physicals, as well as arranging any transportation when safety of the transport is questioned.

I understand that LCCA will be responsible for the following:

- Transportation to and from local routine services, medical, and dental appointments.
  SPECIAL NOTE: The current dentist used for Lighthouse Care Center of Augusta is in North Augusta, South Carolina. I understand that this office is officially in the state of South Carolina and agree that, if needed, my child/resident has permission to be taken for treatment.
- LCCA may request that elective surgery be completed post discharge.
- LCCA will transport my child in case of all medical emergencies.
- LCCA may include recommendations for non-emergency needs in the discharge summary.
- LCCA will supply basic hygiene items for my child / resident.

Advance Directives: **Accept:_____** **Decline:_____**

Do you have an Advance Directive related to end of life care? [ ] No [ ] Yes and I acknowledge that I have been asked to provide a copy of my Advance Directive to LCCA for my medical record.
Do you have an Advance Directive related to psychiatric crisis? [ ] No [ ] Yes and I acknowledge that I have been asked to provide a copy of my Advance Directive to LCCA for my medical record.
The undersigned acknowledges the following regarding Advance Directives:

- I understand that I am not required to have an Advance Directive in order to receive treatment at LCCA
- I have been given written materials about my right to accept of refuse medical treatment
- I have been informed of my rights and received information regarding mental health directives
- I have been informed of my rights to formulate, review or revise Advance Directives
- I understand to what degree LCCA will fulfill my Advance Directive and have been given written material stating these terms
- I understand that requests for DNR or AND will not be honored while at LCCA
- I have been informed of my right to request assistance to formulate an Advance Directive related to end of life or psychiatric crisis.

LIGHTHOUSE CARE CENTER OF AUGUSTA

Patient Label

HTLV-III Antibody Testing Information

Accept:_____ Decline:_____

This is not a test for AIDS. Only complicated special tests done by doctors can tell if a sick person has AIDS. Doctors believe they know what causes AIDS. It is a virus (a kind of germ) called "HTLV-III". Doctors think many people get the virus but only some of these people may go on to get AIDS. The virus spreads in three particular ways: 1) By sexual contact. 2) By blood to blood contact (transfusions with infected blood, for example) 3) By transmission from an infected mother to her infant at birth or during pregnancy. The virus does not spread in other ways and especially not by casual interpersonal contact. If a person gets the virus, his body usually tries to fight back. It does this by making "antibodies" against the virus. The test will only tell if your body has antibodies against the virus in your blood, not if you have AIDS. It cannot tell for sure if the virus is still in your body now. It cannot tell for sure if you might spread the virus to other people. It cannot tell for sure if you will ever get AIDS. The test results can be either "positive" or "negative". A "positive" test result means the antibodies have been found in your blood. A "negative" test means that no antibodies have been found. Sometimes the test can be wrong. A few people who really do have the virus will not have a positive result like they should. A few people who do not have the virus may have a positive result anyway.

There are two main reasons for doing the test:

1. To test blood in blood banks: Some people have gotten AIDS from blood they received as part of their medical treatment. The blood banks will test all donated blood. To be safe, they will destroy any blood that has a positive test.
2. To answer questions individuals may have regarding their own particular exposure to the virus. You may be concerned that you are infected. The test can help answer that concern, but you must first understand the nature of the virus, how it does and does not spread, and what you as an individual will need to do if you test positive.

Health advice you will receive will be the same whether your test is positive or negative:

- If males have sex with each other, they should limit the number of partners. It is safest to have sex with partners who also limit their partners. They should never give or take any body fluids because the virus that causes AIDS is found in bodily fluids. They should always use condoms because doctors think condoms act as a barrier against the transmission or spread of AIDS.
- If a person takes drugs with a needle, he/she should cut down on drug use and never share needles.
- If a woman has sex with a man who also has sex with other men (bisexual) she should be sure the man she has sex with uses a condom.

Following this advice will decrease your chance of getting or spreading AIDS. Also, if your test is positive, you will be given a list of other things to do to keep from possibly spreading the germ which causes AIDS. You must give your name in order to get the test. If you decide to take the test, it will be up to you to keep your appointment to get the results. Any record of your test will be kept as private as the law allows, just like any other medical record. However, effective February 16, 1986, the test results will be reported to the Department of Health and Environmental Control (DHEC) and a permanent record will be maintained. You may want to talk with someone you trust to be supportive and accepting. The undersigned verifies that you have received and read the information on this handout, and had an opportunity to ask questions before the test.

1. I authorize that blood be drawn for HIV (HTLV) Antibody Testing if my physician considers the test to be necessary.
2. I understand that this "HIV Antibody Test" is not a diagnostic test for AIDS.
3. I have been advised of the implications of the test and have been given an opportunity to ask questions and have my questions answered.
4. I acknowledge that I have received and read the DHEC materials "HTLV-III Antibody Testing Information".
5. I understand that DHEC and Lighthouse Care Center of Augusta will maintain the confidentiality of the test results, medical records, and reportable information.
6. I understand that my physician will review my test results and that results will only be given to me in person.
7. I understand that Lighthouse Care Center of Augusta may elect NOT to test for HIV antibodies even though I have signed this Consent Form.

SIGNING BELOW I CERTIFY AND AGREE THAT:

1. I have read and fully understand the information noted on this form. Those explanations (if necessary) were made to me and that I was afforded an opportunity to ask questions and have my questions answered in a language I could understand.
2. That I authorize that the procedures and other issues outlined in this form may be administered to me (the patient).
3. That if a physician so directs, other clinical staff, consultants, and/or contractors of LCCA may also be involved in administering the psychiatric/medical treatment.
4. I also acknowledge that there are no physical conditions/limitations that prevent my (the patient's) participation in the activities and/or treatments agreed to in this consent.

That I have the right to refuse some or all of the treatments and procedures noted on this form. That if I so desire that I have made my wishes known in the space provided below.

Parent/Legal Guardian Date **Relationship** **Lighthouse Staff Signature Date**

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

EMERGENCY SAFETY INTERVENTIONS AND CONTAINMENT POLICY AND NOTIFICATION PROCEDURE

LCCA uses Emergency Safety Interventions when there is a crisis situation and the immediate safety of the child or others exist. ESI is utilized when no less restrictive intervention has been, or is likely to be, effective in averting danger.

Containment is an ESI that is defined as any manual/physical method that temporarily restricts/reduces or limits an individual's freedom of movement or normal access to one's body, without the individual's permission. It is utilized in this program only after all avenues of verbal de-escalation and less restrictive methods have been tried and have failed and there is a clear and present danger to the resident, staff or other residents.

- Only staff that have been trained, qualified, and are proven competent in containments and containment monitoring are allowed to utilize these techniques.
- Containment is used only in the case of emergency, when there is imminent risk of harm to the resident or others and when non-physical interventions would/have been ineffective.
- Physical containment techniques are used only after less restrictive methods of interventions have been tried and failed and all other means of verbal de-escalation have been expended.
- All avenues of verbal de-escalation should be attempted prior to any physical containment of a child. These actions are taken in an attempt to defuse the situation and avoid an ESI.
- Containments are deemed as a last resort in the effort to manage behavior in emergency safety situations. Containments are never used as a threat or form of punishment or discipline, coercion, retaliation, in lieu of adequate staffing, humiliation, replacement for active treatment, for property damage not involving imminent danger, or as a convenience to staff.
- When the resident's behavior is evaluated to be safe or the threat of harm has been safely minimized the containment is then discontinued, and the ESI will end.
- A resident and/or their parent/legal guardian are allowed to file a grievance anytime they feel like their rights have been violated. If needed, please refer to the Resident/Parent Handbook for additional information.

It is the procedure of this facility to notify the legal guardian, within eight hours of any containment initiated. I acknowledge that I have been informed of LCC's policy regarding the use of ESI and containments; I furthermore give my permission for these safety procedures {ESI and containments} to be implemented should an emergency crisis situation arise. In addition, I certify that there are no reasons that the use of any ESI could be determined to be inappropriate for use on the above mentioned child due to any medical or psychological condition. I understand the information provided to me and may receive a copy of this form upon request.

Please name the family member to be notified:

Name:_____ **Relation:**_____

Telephone Number:_____

_____ _____

Parent/Legal Guardian Signature **Date**

_____ _____

Lighthouse Care Center Staff Witness Date

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

CONSENT TO ACKNOWLEDGE YOUR PRESENCE HERE

All patients have a right to receive approved visitors, phone calls, and mail, while a patient at Lighthouse Care Center of Augusta. A code will be given by Intake staff upon admission. **It is the patient's guardian's responsibility to communicate the confidentiality code to the identified persons on the list.**

CONFIDENTIALITY CODE

Please complete in full (with phone numbers) for all listed, beginning with Parents/Guardians.

Name & Address	Relationship	Phone Number	Permissions	
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.
			☐ Phone ☐ Mail	☐ Visitation ☐ Medications ☐ Authorized to pick-up pt.

Patient/Guardian Signature ______________________ **Date** ______________

If not patient, relationship to patient______________________

Lighthouse Staff Signature______________________ **Date** ______________

REQUEST FOR NON-DISCLOSURE OF PRESENCE HERE

Signatures only required if (read below)

I voluntarily request that Lighthouse Care Center of Augusta keep the knowledge of the presence of the patient indicated above strictly confidential and not give out information about the patient to anyone. Therefore, I waive the right to receive phone calls, visitors, mail as acceptance of these would acknowledge presence.

Patient/Guardian Signature ______________________ Date/Time ____________

If not patient, relationship to patient ______________________

Witness ______________________ Date/Time ____________

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP

Patient Label

TELEHEALTH INFORMED CONSENT

Patient Name: _____ **Date of Birth**: _____

Distant Site (participating family members) via Telehealth: _____

Email Address: _____

Originating Site/ Provider Location via Telehealth: ☐ Lighthouse Care Center of Augusta

INTRODUCTION

You are going to have a clinical visit using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

Technology:
It is the policy of LCCA to use the secure televideo technology for Telemedicine/Telehealth services.

The Process:
You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconferencing technology, you may reject the use of the technology and schedule a traditional face-to-face encounter. Safety measures are implemented to insure that this videoconference is secure, and no part of the encounter will be recorded.

Possible Risks:
There are potential risks associated with the use of telehealth which include, but may not be limited to:

- A provider may determine that the telehealth encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telehealth:
I have read and understand the information provided above regarding telehealth, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

I hereby authorize Lighthouse Care Center of Augusta to use telehealth in the course of my diagnosis and treatment.
(Agency or Physician Name)

Signature of Patient (or Authorized Person) _____ **Date** _____

If Authorized Signer, relationship to patient _____

Lighthouse Staff Signature _____ Date _____

LIGHTHOUSE
CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

AUTHORIZATION TO RELEASE and/or DISCLOSE HEALTH INFORMATION

This will authorize the Treatment Team of Lighthouse Care Center of Augusta to release or disclose specific health information from the records of the above named patient to:

*Name of Organization and Name of Person/Department (**Must be filled out at admission**)*

Address / Telephone Number / Fax Number

The purpose(s) of this release or disclosure is:

❑ at the request of the individual whose signature appears below and who elects not to provide a statement of purpose;

❑ as follows:

The specific information to be released or disclosed is:

❑ Discharge Summary	❑ Psychiatric Evaluation	❑ Labs Results
❑ Biopsychosocial	❑ Health/Physical Evaluation	❑ Admit/Discharge Dates
❑ Psychological Testing	❑ Other:	

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER DATE SIGNED BELOW.

- **I understand** that I may revoke this Authorization in writing at any time, except to the extent this Authorization has already been acted upon prior to the effective date of revocation.
- **I understand** that the information being disclosed may not be protected from re-disclosure by the recipient of the information unless prohibited by state or federal law.
- **I understand** that if the specific record information that is the subject of this Authorization contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, the disclosure I am hereby authorizing will include that information.
- **I understand** that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; except that, if a service is solely for the purpose of creating health information for disclosure to a third party (for example, an employer or insurance company), service may be denied if authorization to disclose the information (for example, results of a physical examination) is not given. Also, if research related, treatment may be denied if authorization is not given.
- **I understand** that I may request a copy of this signed Authorization.

Patient's Signature	**Date**
Sign Here	
Signature Of Legal Guardian	**Date**
Lighthouse Staff Member's Name	Date

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient La bel

AUTHORIZATION TO RELEASE and/or DISCLOSE HEALTH INFORMATION

This will authorize the Treatment Team of Lighthouse Care Center of Augusta to release or disclose specific health information from the records of the above named patient to:

*Name of Organization and Name of Person/Department (**Must be filled out at admission**)*

Address / Telephone Number / Fax Number

The purpose(s) of this release or disclosure is:

☐ at the request of the individual whose signature appears below and who elects not to provide a statement of purpose;

☐ as follows:

The specific information to be released or disclosed is:

☐ Discharge Summary	☐ Psychiatric Evaluation	☐ Labs Results
☐ Biopsychosocial	☐ Health/Physical Evaluation	☐ Admit/Discharge Dates
☐ Psychological Testing	☐ Other:	

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER DATE SIGNED BELOW.

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- **I understand** that I may request a copy of this signed Authorization.

Patient's Signature	**Date**
Sign Here	
Signature Of Legal Guardian	**Date**
Lighthouse Staff Member's Name	Date

LIGHTHOUSE
CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient La bel

AUTHORIZATION TO RELEASE and/or DISCLOSE HEALTH INFORMATION

This will authorize the Treatment Team of Lighthouse Care Center of Augusta to release or disclose specific health information from the records of the above named patient to:

Name of Organization and Name of Person/Department (Must be filled out at admission)

Address / Telephone Number / Fax Number

The purpose(s) of this release or disclosure is:

☐ at the request of the individual whose signature appears below and who elects not to provide a statement of purpose;

☐ as follows:

The specific information to be released or disclosed is:

☐ Discharge Summary	☐ Psychiatric Evaluation	☐ Labs Results
☐ Biopsychosocial	☐ Health/Physical Evaluation	☐ Admit/Discharge Dates
☐ Psychological Testing	☐ Other:	

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- **I understand** that I may request a copy of this signed Authorization.

Patient's Signature	**Date**
Sign Here	
Signature Of Legal Guardian	**Date**
Lighthouse Staff Member's Name	Date

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

CONSENT FOR HAIR CARE SERVICES

I, _____, give Lighthouse Care Center of Augusta (LCCA)
(Parent/Guardian)
consent to provide hair care services to my son/daughter, _____.
(Child's name)
I understand that these services are being provided by a third party contractor and LCCA is neither responsible nor liable for any mishaps that may take place during this process.
I give my consent for my child to receive:

_____ **cut** _____ **relaxer** _____ **braids**

I DO NOT give my consent for my child to receive:

_____ **cut** _____ **relaxer** _____ **braids**

_____ _____
Signature **Date/Time**

_____ _____
2nd Witness Signature – Telephone Consent Date/Time

I, _____, **DO NOT** give Lighthouse Care Center of Augusta (LCCA) consent to provide hair care services to my son/daughter, _____.

_____ _____
Signature Date/Time

_____ _____
Witness Date/Time

LIGHTHOUSE CARE CENTER OF AUGUSTA

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

Patient Label

REQUEST FOR DUAL RELEASE OF SCHOOL RECORDS

Date: _____

Name of Resident: _____

Date of Birth: _____ Grade: _____

Name of School: _____

School Address: _____

City: _____ State: _____ Zip Code: _____

School Phone Number: _____ School Fax Number: _____

_____ is in placement at Lighthouse Care Center of Augusta where he/she will be receiving
(Name of Resident)
therapeutic homebound instruction as deemed appropriate. In order to deliver thorough treatment services, we ask that the following information be released to our attention:

❑	Official School Transcript	❑	Immunization Records
❑	Current Grade / Class Placement	❑	Psycho educational / Testing Results
❑	IEP and any updates / addendums	❑	Testing Results
❑	Attendance Records	❑	Achievement Test

PERMISSION TO RELEASE RECORDS

I hereby give my written permission to the administration and/or staff of _____
(School)
to release the records indicated above to Lighthouse Care Center of Augusta and for Lighthouse Care Center of Augusta to reciprocate in releasing new educational information back to the school district.

The information in these documents is confidential and privileged. It is intended only for the purpose of the individual or entity named above. If the reader of these documents is not the intended recipient, you are hereby notified that any dissemination, distribution, or duplication of this information is strictly prohibited. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
(Legal Guardian's Signature) **(Date)**

_____ _____
(Lighthouse Staff Signature) (Date)

Richmond County School System

SPECIAL EDUCATION & SUPPORT SERVICES

Talithia F. Newsome
DIRECTOR

864 Broad Street
3rd Floor
Augusta, GA 30901

Phone: (706) 826-1132
FAX: (706) 826-4649

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Records are requested from:

_____ Name

_____ Agency

_____ Street

_____ City, State & Zip

Records are to be forwarded to:

Tameka Smith Name

RCSS - SESS Agency

864 Broad Street – Third Floor Street

Augusta, GA 30901 City, State & Zip

You are hereby authorized to release confidential information on the following student:

_____ Student's Name (as shown on cumulative record) _____ Date of Birth

Records Requested

- __X__ Initial Eligibility & Permission to Place
- _____ Education Evaluations
- __X__ Psychological Evaluations
- __X__ Medical Records
- __X__ Most Current IEP
- _____ Minutes of Placement
- __X__ Transition Plan/Behavior Intervention Plan
- __X__ Eligibility Report
- _____ Related Services Information

Reason for Release

- __X__ Educational Planning and/or Placement
- __X__ Maintenance of Student Records
- __X__ Medical Problems Related to Learning
- __X__ Proof of Disability
- _____ Transition Services
- _____ Other

_____

_____

_____

I am aware that there is information within my child's file which has been received from the following third party agencies:

_____

_____

_____

I (____ do / ____ do not) give consent to have this information forwarded to the designated agency above.

_____ Signature of Parent of Guardian

_____ Relationship to Student

_____ Date

_____ Witness (School Official)

_____ Position

_____ Date

Patient Information (Please print in ink)

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip Code | Phone Number

Social Security # | Date of Birth | Age | Male or Female | Preferred Language

School | Grade | Optional Information (for statistical purposes only): Race/Ethnicity

Patient Health History (Please answer all questions)

ADHD (Attention Deficit Hyperactivity Disorder)	Yes __ No __	Use of Diet Pills/Diet Aids (including Phen-Fen)	Yes __ No __	Kidney or Liver Disease	Yes __ No __
Alcohol/Drug Abuse	Yes __ No __	Disabilities/Special Needs	Yes __ No __	Pregnant	Yes __ No __
Allergies	Yes __ No __	Epilepsy	Yes __ No __	Prosthetic Joints, Plates or Pins	Yes __ No __
Anemia	Yes __ No __	Fainting	Yes __ No __	Rheumatic Fever	Yes __ No __
Asthma/Breathing Problems	Yes __ No __	Heart Murmur	Yes __ No __	Sickle Cell Anemia	Yes __ No __
Autism	Yes __ No __	Heart Trouble	Yes __ No __	Speech/Hearing Problems	Yes __ No __
Birth Defect(s)	Yes __ No __	Hepatitis	Yes __ No __	Has the patient had surgery?	Yes __ No __
Bleeding/Clotting Problems	Yes __ No __	High Blood Pressure	Yes __ No __	Tobacco Use	Yes __ No __
Diabetes	Yes __ No __	HIV/AIDS	Yes __ No __	Tuberculosis	Yes __ No __

If you answered "Yes" to any of the above, please explain:

Yes ____ No ____ Does the patient have any other health problems? If "Yes", please explain

Yes ____ No ____ Is the patient taking any medications at this time (including over-the-counter medications such as aspirin)? If "Yes", what type:

Yes ____ No ____ Is the patient allergic to any medications? If "Yes," what?:

Yes ____ No ____ Is the patient allergic to anything else? If "Yes", what (for example: latex, anesthesia)?:

Yes ____ No ____ Does the patient have any dental problems/concerns at this time? If "Yes, please explain:

Parent/Guardian Information (Please Print)

Mother/Guardian Name | Father/Guardian Name | Parent/Guardian Email Address

Address | City | Zip Code | (____) Home Phone # | (____) Cell or Work Phone #

Nearest Relative Not Living With Patient | Relationship to Patient | (____) Phone #

Please List Other Siblings Seen At This Center:

Patient's Pediatrician/Family Physician | (____) Patient's Pediatrician/Family Physician's Phone # | Signature of Dentist

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I consent for the examination, teeth cleaning, application of topical fluoride, any necessary x-rays and clinical photographs, and any necessary sealants.

Parent/Guardian Signature | Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices. I acknowledge that I have had the full opportunity to read the Notice of Privacy Practices.

[NOTE: If there is more than one patient in same family, please list ALL patients]

_____
Patient(s) Name

_____ _____
Patient's Parent / Guardian / Responsible Party Relationship to Patient

_____
Signature of Parent / Guardian / Responsible Party

_____
Date

FOR OFFICE USE ONLY – When Parent / Guardian / Responsible Party Does NOT Sign

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____ _____
Signature of Office Representative Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION *AND* AUTHORIZATION OF PERSONS TO CONSENT FOR TREATMENT IN THE ABSENCE OF PARENT/GUARDIAN

This form is to be completed by the parent/guardian of a minor (under age 18) patient, if the parent/guardian wishes to authorize other individuals (such as a grandparent, aunt/uncle or family friend) to accompany the minor patient to appointments and consent to treatment of the minor patient. When the patient reaches age 18 or if the patient has been legally emancipated, the parent/guardian no longer has the right to consent to treatment or to authorize anyone else to do so.

SECTION A: PATIENT INFORMATION [If more than one patient in same family, please list ***ALL*** patients below]:

Patient Name(s):_____

Address:_____

Telephone:_____ Alt. Telephone:_____

SECTION B: INDIVIDUAL AUTHORIZING ON BEHALF OF PATIENT

Name:_____ Relationship to Patient:_____

[**NOTE:** If there is a custody agreement, this individual must be the person who has healthcare decision-making rights for each child listed above. Both parents are authorized to consent for minor patient in the absence of a court order removing one parent's rights.]

□ Check here if address and phone # are same as patient's listed above in Section A

If Different: Address: _____

Telephone:_____ Alt. Telephone:_____ Email:_____

OTHER PARENT/GUARDIAN:

Name:_____ Relationship to Patient: _____

□ Check here if address and phone # are same as patient's listed above in Section A

If Different: Address: _____

Telephone:_____ Alt. Telephone:_____ Email:_____

SECTION C: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

By completing and signing this form, you authorize the disclosure of protected health information (PHI) of the minor patient(s) and/or authorize the accompaniment for treatment and consent for the treatment** of the above-listed minor patient(s) in the absence of the parent/guardian. You may check either or both boxes beside an individual's name. ***PLEASE NOTE***: Unless step-parents, grandparents, aunts, uncles, neighbors or others are named as legal guardians of the patient, you should include their names here if you would like for them to have access to patient's chart or to be able to accompany the patient for treatment and consent to treatment.

	PHI Disclosure	**Patient Accompaniment and Consent to Treatment****
Individual's Name: _____	☐ _____	☐ _____

Relationship to Patient:_____

Address: _____

_____

Phone #:_____

Individual's Name: _____	☐ _____	☐ _____

Relationship to Patient:_____

Address: _____

_____

Phone #: _____

Individual's Name: _____ ☐ _____ ☐ _____

Relationship to Patient: _____

Address: _____

_____

Phone #: _____

I understand that the Dental Center will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

_____ _____

Parent/Guardian Signature
(MUST MATCH information in Section B above)

Witness (Center Employee) Signature

_____ _____

Date

Witness Name & Job Title

[NOTE: Notary required only if form is completed <u>outside of the Center.</u>]

Sworn before me this_____ day of _____, _____ , in the County of _____, State of _____.

_____ (seal)

Notary Public

_____ _____ My commission expires:_____

State County

SECTION D: I understand that I may revoke this authorization in writing submitted at any time to the address listed on the front of this notice, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will expire two years from the date of my signature.

**NOTE: Some state laws may prohibit the delegation of the right to consent for a patient, unless in a Durable Power of Attorney or in guardianship papers.

You are entitled to a copy of the authorization after you sign it. A copy will be included in the patient's chart.

SECTION E: REVOCATION OF AUTHORIZATION FOR PERSONS TO CONSENT FOR TREATMENT

I revoke the following authorization(s) [NOTE: Check ONLY the authorization(s) that apply]:

☐ Authorization for Disclosure of Protected Health Information ☐ Authorization for Persons to Consent for Treatment

Individual(s) for whom authorization(s) specified above is revoked (list ONLY those individuals that apply):

_____ _____

I understand that revocation of such authorization(s) will not affect any action the Dental Center takes in reliance on such authorization(s) before receiving this written Notice of Revocation. I also understand that the Dental Center may decline to treat or to continue to treat patient after I have revoked such authorization(s).