Path Behavioral HealthIntake Packet Program: MHR ☐ IOP ☐

Today's Date: _____

Client Name: _____ **DOB:** _____

Primary Language: _____ **Secondary Language:** _____

Race/Ethnicity: _____

Primary Insurance Name: _____ **Policy #:** _____

Secondary Insurance: N/A **Policy #:** N/A

SSN: _____

IDENTIFYING INFORMATION

Home Address: _____

City: _____ **Zip Code:** _____ **Home Phone:** _____

Email Address: _____

School/Grade: _____

Legal Guardian Name/Phone: Adult

Mother's Name: N/A **Daytime Phone:** N/A

Father's Name: N/A **Daytime Phone:** N/A

EMERGENCY CONTACT

Name: _____ **Relationship to Client:** _____

Daytime Phone: same as cell **Evening Phone:** same as cell **Cell:**

Physician's Name/Phone: _____

Others in the Home (Names/Relationship to Client/Ages if appropriate): _____

_____

Significant Others Involved with Client: _____

Have you/your child ever had a vision test? If yes, what were the results?
Are glasses/contacts required? If so, when should they be worn?
Have you/your child ever had a hearing test? If yes, what were the results?

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: _____

_____

Recent Treatment History (last 12 months): _____

Pertinent Medical Issues: _____

Any current infectious disease(s)? _____

Client Medications: See Med List

_____

Pharmacy: _____

Pharmacy Address: _____ **Pharmacy Number:** _____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges: _____

Client Name: Record Number:

CONSENTS/RIGHTS INFORMATION

1. **Consent for Electronic Signature (Optional)**

This is to certify my request for an electronic signature. Through the use of an electronic signature, I agree that the information I provide is accurate and complete to the best of my knowledge. I agree that the electronic signatures appearing on this agreement (and other documents that require electronic signatures provided by Path Behavioral Health) are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility. Please note that you may withdraw your consent to sign documents electronically at any time. In order to withdraw consent, you must notify Path Behavioral Health that you wish to withdraw consent and request that your future documents be prepared in paper format.

Client/Parent/Guardian: _____ **Date:** _____

2. **Consent for Treatment**

I hereby give my consent for **Therapist** to provide mental health services to me/my child. I have been informed of the scope and purpose of the service and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: _____ **Date:** _____

3. **Financial Release**

I understand that **Therapist** may use confidential information about me to bill and be paid for services. I hereby consent for **Therapist** to release information to the billing agent, **Integrity Support, Inc.** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Therapist** and **Integrity Support, Inc.** for this purpose.

Client/Parent/Guardian: _____ **Date:** _____

4. **Permission to Transport**

I hereby grant permission for **Therapist**, to provide transportation to my child, and agree to hold **Therapist** harmless for any accident/injury that results from the provision of transportation.

Client/Parent/Guardian: _____ **Date:** _____

5. **Permission to Seek Emergency Medical Care**

I hereby give consent for **Therapist**, to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Therapist** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: _____ **Date:** _____

6. **Client Rights/Grievance Policies (See Handout)**

I have received and had explained to me the Client Rights handout. **Therapist** gave me this

Client Name: Record Number:
handout and verbally explained my rights as a client.

Client/Parent/Guardian: _____ **Date:** _____

7. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Therapist** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: _____ **Date:** _____

8. Telemedicine Consent

I agree to participate in Telemedicine services offered through Path Behavioral Health including outpatient therapy and medication management. I understand that I have the option to schedule appointments with Path Behavioral Health's Psychiatrist, Medical Psychologist, Psychiatric Nurse Practitioner, or Outpatient Therapist in another Path Behavioral Health office that supports an on-site practitioner. However, such a face-to-face appointment may require a wait time from one to 4 weeks and commuting from out of town will be at my own expense.

Client/Parent/Guardian: _____ **Date:** _____

9. Communication

I understand that one of my rights is to be able to choose how I am contacted.
I ☑ ***do*** ☐ ***do not*** give permission for **Therapist** to contact me at work.
Furthermore, I ☑ ***do*** ☐ ***do not*** give permission for **Therapist** to leave voice messages for me at ☐ ***home*** ☐ ***work*** ☑ ***both*** ☐ ***neither***.

Client/Parent/Guardian: _____ **Date:** _____

10. Drug Testing Consent **Required for Intensive Outpatient Program 13 and up**

I hereby agree, upon a request made under the drug/alcohol testing policy of Path Behavioral Health, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to discharge after consultation of treatment team. I further authorize and give full permission to have the Company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company. I UNDERSTAND THAT THE COMPANY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL, AND I AGREE TO SUBMIT TO ANY SUCH TEST. I ALSO UNDERSTAND THAT I AM SUBJECT TO RANDOM ALCOHOL AND/OR DRUG TESTS.

Client/Parent/Guardian: _____ **Date:** _____

I, **Therapist**, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

Signature: _____ **Date:** _____

Print: _____

Path Behavioral Health

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Shreveport Location: 6811 Fairfield Ave. Shreveport, LA 71106 318.216.5088 (phone), 318.670.3975 (fax)
New Iberia Location: 177 Duperier Avenue New Iberia, LA 70560 337.419.3586 (phone), 337.753.7454 (fax)

Client and Family Orientation Checklist

The following information has been provided as part of the consumer orientation. Signatures below indicate that each area has been fully explained and is understood by the consumer. The recipient handbook has also been provided in the orientation.

Services provided, days and hours of operation, expected level of participation
Client Rights and Rights of Minor Patients
Code of Ethics/Conduct
Grievances and Appeal Procedures
Discharge Procedure
Confidentiality/HIPAA
Education about advanced directives
Use of Seclusion and Restraint
Policy on Tobacco Use
Medications
Illegal Drugs
Weapons
Religion and Spirituality
After Hours Crisis Line
Emergency Preparedness
Privacy Statement
Identification of the person responsible for service coordination
Program Rules
Person-Centered Plan Development/Collaboration during initial assessment every 6 months (or as needed)
Assessments conducted by LMHP on admit and yearly (or as needed)
Collaboration with PCP, school, and appropriate referral sources (with authorization to release)

Client Name / Signature:
Legal Guardian Name / Signature: Adult
LMHP Name / Signature:
Date:

Telehealth Services

Telehealth involves the use of electronic communications to enable Path Behavioral Health to connect with individuals using interactive audio, video, telephone and/or other audio/video communications and includes the practice of delivery of services such as assessments, diagnosis, consultation, transfer of medical and clinical data, psychoeducation, referral to resources, psychotherapy/therapy, and additional Mental Health Rehabilitation (MHR) services approved by Louisiana Department of Health (LDH).

Considerations regarding Telehealth Services:

Comfort with technology varies among people and therefore, use of telemental health or "telehealth" requires a comfort and proficiency with technology. Path Behavioral Health will work to assess with you whether you might be a fit for telemental health prior to engaging in services.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality about my treatment and related communications via telehealth. The laws that protect confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during my treatment is generally confidential with exceptions for safety and legal implications, as expressed in the Informed Consent document.

2. I understand that there are risks associated with participating in telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of Path Behavioral Health, that my sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and Path Behavioral Health may occur via telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each telehealth session Path Behavioral Health is required to verify my full name and current location.

6. I understand that in some instances telehealth may not be as effective or provide the same results as in-person treatment. I understand that if Path Behavioral Health believes I would be better served by in-person, it will be discussed with me and services will be transitioned to in-person with Path Behavioral Health. If such services are not possible because of distance or hardship, I will be referred to other providers who can provide such services.

7. I understand that while telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that telehealth is effective for all individuals. Therefore, I understand that while I may benefit from telehealth, results cannotbe guaranteed or assured.

8. I understand that some telehealth platforms allow for video or audio recordings and that neither I nor Path Behavioral Health may record the sessions without the other party's written permission.

Client Name: Record Number:

9. I understand that Path Behavioral Health will make reasonable efforts to provide me with emergency resources in my geographic area.

Emergency Procedures Specific to Telehealth Services

If you have a mental health emergency, Path Behavioral Health encourage you not to wait for communication back from provider, but do one or more of the following:

- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice (nearest emergency room is recommended).
- Call Biltmore Health Services Crisis Line

There are additional procedures that we need to have in place specific to telehealth services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and/or telehealth services are not appropriate.

- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. This person is the person indicated in the informed consent processed identified as your emergency contact.

- You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

- Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

I have read and understand the information provided above, have discussed it with Path Behavioral Health and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Client/Parent/Guardian Signature:

Client Name:

LMHP Signature:

Verbal Consent Obtained

Path Behavioral Health reviewed Telehealth Consent Form with client, client understands and agrees to the above terms, and client has verbally consented to receiving services from Path Behavioral Health via Telehealth.

Staff Name:

Date of Verbal Consent:

Lafayette Location: 202 General Gardner Lafayette, LA 70501 337-232-9457, 337-232-9459 (fax)
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Path Behavioral Health

AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF INFORMATION

CLIENT NAME: _____ MR#: _____

Insurance ID#: _____ DOB: _____

I hereby request and authorize **Path Behavioral Health** or contracted agent to release and exchange information to:
(Name of agency/person/facility or program authorized to use or disclose information)

Person/Agency	Address	Phone No.	Fax No.
_____	_____	_____	N/A

(The following information will be released or exchanged (mark all that apply)

☐ Psychological Evaluation	☐ Medication History
☐ Psychiatric Evaluation	☐ Admissions Assessment
☐ Progress Note **Does not include client session notes from assigned therapist(s)**	☐ Insurance Information
☐ Discharge Summary	☐ HIV/AIDS information
☐ Treatment Plan and Diagnosis	☐ Labs
☐ Alcohol/Drug treatment	☐ IEP, 504 Plan, Grades
☐ Emergency Contact	☐ Other (specify):

Time Frame of Information to be Released _____ to 90 days post D/C.

The purpose of this disclosure is for: ☐ Assistance with treatment ☐ Referral ☐ Emergency Contact ☐ Collaboration ☑ Client request

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has HIV/AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to state law shall be strictly confidential.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on the consent. In any event, if not revoked earlier this authorization expires automatically one year (365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **BPath Behavioral Health will** begin and continue client's treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information will be disclosed.

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

☐ **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian.**

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Staff, if revoked verbally _____ Date: _____

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Person/Agency Address Phone No. Fax No.

_____: _____: _____: _____

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Person/Agency	Address	Phone No.	Fax No.
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Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

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Path Behavioral Health

AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF INFORMATION

CLIENT NAME: _____ MR#: _____

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I hereby request and authorize **Path Behavioral Health** or contracted agent to release and exchange information to:
(Name of agency/person/facility or program authorized to use or disclose information)

Person/Agency	Address	Phone No.	Fax No.
_____	_____	_____	_____

(The following information will be released or exchanged (mark all that apply)

☐ Psychological Evaluation	☐ Medication History
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☐ Progress Note **Does not include client session notes from assigned therapist(s)**	☐ Insurance Information
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Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

☐ **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian.**

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Staff, if revoked verbally _____ Date: _____

PATH Behavioral Healthcare

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

PATIENT NAME: _____ **DOB:** _____

A. Treating Behavioral Health Clinician/Facility Information:

Path Behavioral Health: Lafayette Location: 202 General Gardner Lafayette, LA 70501 337-232-9457, 337-232-9459 (fax) Opelousas Location: 1211 W. Vine St. Suite C Opelousas, LA 70570 337-678-3201, 337-678-3203 (fax) Slidell Location: 350 Gateway Dr. Slidell, LA 70461 985-707-1410, 985-707-1415 (fax) Shreveport Location: 6811 Fairfield Avenue Shreveport, LA 71106 318-216-5088; 318-670-3975 (fax) New Iberia Location: 177 Duperier Avenue New Iberia, LA 70560 337.419.3586 (phone), 337.753.7454 (fax)

B. P/Medical Practitioner or Other Behavioral Health Practitioner/Facility Information:

Name:	Phone:
Address:	Fax:

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health condition(s):

☐ ADHD/ Behavior Disorder ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar Disorder
☐ Depressive Disorder ☐ Anxiety Disorder ☐ Eating Disorder ☐ Adjustment Disorder
☐ Personality Disorder ☐ Other: _____

2. The patient is taking the following prescribed psychotropic medication(s):

☐ Antidepressant	Name:	Dose:	Frequency:
☐ Mood Stabilizer	Name:	Dose:	Frequency:
☐ Stimulant	Name:	Dose:	Frequency:
☐ Anxiolytic	Name:	Dose:	Frequency:
☐ Antipsychotic	Name:	Dose:	Frequency:

☐ Other (Indicate medication name):_____

3. Expected length of treatment: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. Coordination of care issues/Other relevant information impacting care: _____

_____

Date Mailed or Faxed to Other Practitioner/Facility: _____

(PLACE A COMPLETED COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD)

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 90 days post D/C. I understand that I may revoke my consent at any time.

_____ _____
Patient Signature **Date**

I do not want to have information shared with:

☐ My PCP/Medical practitioner ☐ I am not currently receiving services from a PCP/ other medical practitioner
☐ My other behavioral health practitioner(s) ☐ I am not currently receiving services from any other behavioral health practitioner

_____ _____
Behavioral Health Practitioner/Facility Representative Signature **Date**

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. 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.

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

Health and Wellness Questionnaire

People who are prescribed atypical antipsychotics are at increased risk of developing metabolic syndrome. Many individuals with schizophrenia, bipolar disorder, and psychotic disorder are prescribed atypical antipsychotics to treat the serious symptoms of these disorders. Depression is also linked to higher risk of diabetes and cardiovascular disease. It's critical that these individuals have their weight, blood sugar, blood pressure, and cholesterol routinely monitored by their doctor along with education on healthy lifestyle choices.

Behavioral Health Provider Name: **Path Behavioral Health**	Completing Staff Member Name:	Date Completed:
Member Name:	Insurance ID:	Date of Birth:
Primary Care Provider Name:		

1. Living Situation

Where do you currently live?

☐ House/Apartment ☐ Assisted Living ☐ Shelter ☐ Homeless

Who do you live with?

☐ Alone ☐ Roommate ☐ Partner/Spouse ☐ Adult Family ☐ Minor Children ☐ Supervised

2. Hospital/Office Visit History

In the past 12 months how many times have you:

	Never	1 – 2	3 – 5	6 or More
Visited a doctor's office	☐	☐	☐	☐
Gone to the emergency room	☐	☐	☐	☐
Stayed overnight in a hospital	☐	☐	☐	☐

3. Cholesterol checked

Date of last test:
If unknown: recommendation is to follow up with PCP N/A

4. Glucose Levels checked

Date of last test:
If unknown: recommendation is to follow up with PCP N/A

5. Vitals

Date taken: N/A

Temp:	Pulse:	BP:	Height:	Weight:	BMI:	Waist:
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Biltmore Health Services

Health and Wellness Questionnaire

6. Social Activity

How often do you do the following:				
	Never	Rarely	Sometimes	Frequently
Receive invitations to go out and do things	☐	☐	☐	☑
Talk to someone about personal/family problems	☐	☐	☐	☑

7. Physical Activity

How often do you do the following:				
	Never	Rarely	Sometimes	Frequently
Go to the gym	☐	☐	☐	☐
Walk or run	☐	☐	☐	☐
Other	☐	☐	☐	☐

8. Preventative Test History

When was the last time you've had:						
	Never	Less Than 1 Year	1 – 2 Year	3 – 4 Year	5 + Year	Don't Know
Colon cancer screen	☐	☐	☐	☐	☐	☐
Flu vaccine	☐	☐	☐	☐	☐	☐
Pneumonia vaccine	☐	☐	☐	☐	☐	☐
Tetanus vaccine	☐	☐	☐	☐	☐	☐
Dental exam	☐	☐	☐	☐	☐	☐
Pap test	☐	☐	☐	☐	☐	☐
Mammogram	☐	☐	☐	☐	☐	☐

9. Chronic Condition History

Do you have any of the following conditions:					
	Never	In the Past	Currently Diagnosed	Currently Taking Medication	Under Medical Care
Allergies	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bronchitis/COPD	☐	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart problems	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐

Considering your age, how would you rate your overall health:				
Poor	Not Good	Average	Good	Excellent
☐	☐	☐	☐	☐

Health and Wellness Questionnaire

10. Wellness Education: Please check the topics you would like additional information on:

Topics	Yes	No	Uncertain
Nutrition		✔	
Healthy Cooking		✔	
Physical Activity/Exercise		✔	
Smoking Cessation		✔	
Stress Management		✔	
Recovery Activities		✔	
Peer Support		✔	
Medical Management		✔	
GED		✔	
Vocation/PreVocation		✔	
Other, specify:			

ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind, willfully and
Name of Principal
voluntarily make this advance directive for mental health treatment. I want this directive to be followed if I become incapable. I become "incapable" when two physicians determine that, due to any infirmity, I am currently unable to make or to communicate reasoned decisions regarding my mental health treatment**.**

If I become incapable, I want my mental health treatment decisions to be made: (INITIAL ONLY ONE)

_____ According to the preferences or instructions specifically authorized in this advance directive. I am not appointing a representative at this time.

_____ By my appointed representative according to the preferences or instructions specifically authorized in this advance directive, or, if my desires are not set forth in an advance directive or otherwise known by my representative, in what my representative believes to be my best interest.

1. Designation of Mental Health Treatment Representative.

Each person I appoint must accept my appointment in writing in order to serve as my representative. By law, my representative is authorized to receive information regarding mental health treatment and to receive, review, and authorize disclosure of medical records relating to that treatment, unless limited by federal law or by my advance directive. Limits, or additional directions, if any:

I understand that I am not required to appoint a representative in order to complete this advance directive.

I hereby appoint the following person to act as my representative to make decisions regarding my mental health treatment if I become incapable :

Name_____

Address_____

Phone #_____

(*Alternate Representative - - Optional*)

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

Name N/A

Address N/A

Phone # N/A

2. Psychoactive Medications

If it is determined that I am incapable, my wishes regarding psychoactive medications are as follows:

A. The administration of the following medications:

B. The administration of medications considered appropriate by my physician, Dr. _____ , phone # _____ .

C. The refusal of the administration of the following medications. Consider giving reasons. (I understand that my refusal to accept certain medication(s) may be overruled if the medication is medically essential

and the most medically appropriate. This determination is made in an administrative review in which I am provided legal counsel, and is more fully spelled out in R.S. 28:230):

3. Admission to and Retention in Treatment Facility

In the event I become incapable:

A. _____ I hereby authorize my voluntary admission to a mental health
Initial if yes
treatment facility for a period of [redacted] days (cannot exceed 15 days).

B. Preferences for Treatment (I understand my preferences may not be available):

i. In the event treatment at a treatment facility is necessary, I would prefer to be treated at the following treatment facilities (in order of my preference)

a. _____

b. _____

c. _____

ii. I would prefer not to be treated at the following treatment facilities (consider giving reasons)

a. _____.

b. _____

c. _____

iii. My preference for a treating physician is

C. I desire that the following individual(s) be notified immediately when I have been admitted to a mental health treatment facility:

i. Name: _____

Relationship: _____

Phone:_____

ii. Name: _____

Relationship: _____

Phone:_____

4. Electroshock Therapy

A. If it is determined that I am incapable, my wishes regarding electroshock therapy are as follows (consider giving reasons for your decision):

i. _____ I consent to the administration of electroshock therapy. (An involuntary patient must have a hearing before the administration of electroshock therapy, even if he gives consent)

ii _____ I do not consent to the administration of electroshock therapy (consider giving reasons, conditions, and/or limitations):

5. Additional Information

A. I authorize _____ to apply for, and administer,
Name of person
governmental benefits in my name.

B. I give permission for_____ to receive, review,
Name of person
and consent to disclosure of medical records relating to the treatment of my mental illness.

C. Other matters (consider including mental or physical health history, dietary

requirements, religious concerns, and other matters of importance):

YOU MUST SIGN HERE
FOR THIS DIRECTIVE TO BE EFFECTIVE:

_____ _____
Signature *Printed Name and Date*

AFFIRMATION OF WITNESSES

I affirm that the person signing this directive:

(a) Is personally known to me;

(b) Signed or acknowledged his or her signature on this directive in my presence;

(c) Does not appear to be currently unable to make or to communicate reasoned decisions regarding his mental health treatment and does not appear to be under duress, fraud or undue influence;

(d) Is not related to me by blood, marriage, or adoption;

(e) Is not a patient or resident in a facility that I or my relative owns or operates;

(f) Is not my patient and does not receive mental health services from me or my relative; and

(g) Has not appointed me as a representative in this document

Witnessed by:

_____	_____	
Signature	*Printed Name*	*Date*
_____	_____	
Signature	*Printed Name*	*Date*

ACCEPTANCE OF APPOINTMENT AS REPRESENTATIVE

I accept this appointment and agree to serve as a representative to make mental health treatment decisions for _____. I understand that I must act consistently
Name of Principal
with the desires of the person I represent, as expressed in this directive or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be the person's best interest. I understand that this document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by two physicians. I understand that the person who appointed me may revoke this directive in whole or in part by communicating the revocation to the treating physician or other provider when the person is not incapable.

_____ _____

Signature of Representative *Printed Name* *Date*

_____ _____

Signature of Alternative Representative *Printed Name* *Date*