bridges
a community support system

WELCOME TO BRIDGES...A COMMUNITY SUPPORT SYSTEM, INC.

We are pleased that you have chosen us as your provider for behavioral health services. We look forward to serving you.

At Bridges, we strive to provide the highest quality of care. Should you have any questions or concerns, please let us know by contacting the staff member you are seeing. If necessary, please ask about our consumer grievance procedures.

The purpose of this Welcome Packet is to orient you to the agency and identify what you might expect when you receive services. The packet also includes forms that we will need to review with you and have you sign.

We hope we can provide you with a positive experience and the supports to meet your goals.

Sincerely,

Barbara DiMauro,
President/CEO

WELCOME PACKET TABLE OF CONTENTS

Bridges Mission, Vision and Values Policy

Bridges mission is to provide a broad range of community based behavioral and healthcare services to the residents of our area. We respond effectively to the needs of adults, children and families with a comprehensive range of prevention, mental health and addiction recovery programs. We are committed to creating a Healthcare Home for all the people we serve.

Vision for the Community:

We envision a community in which all people, regardless of age, race, gender, sexual preference, religious beliefs, disability or financial status have access to high quality and comprehensive behavioral and healthcare services. We envision a community of compassion, which responds effectively and respectfully to the needs of all members of the community.

Vision for People We Serve:

We envision a person-centered community support system to help families and individuals lead healthy, fulfilling and productive lives. We envision a strong, dynamic and flexible organization that is a model in the provision of behavioral and healthcare services. We envision Bridges as a leader in advocacy and education on behalf of our clients.

Values:

We value the individual:
At Bridges, the dignity and rights of each individual is respected. We believe that all people have the right to the best behavioral health services available, regardless of their circumstances. We believe that all people have the right to enjoy full and productive lives. We believe in empowering individuals to reach their full potential.

We value our staff and volunteers:
We commit to excellence and diversity among our board of directors, staff and volunteers. We build on our strengths and encourage teamwork, flexibility, innovation and professional growth. We conduct our services and activities in accordance with the highest ethical and professional standards.

We value community and family:

We strive to continually improve our programs, always maintaining our sense of accountability and responsibility to the community we serve. We develop new programs that respond to the changing needs of our community. We support family members in developing meaningful roles in the care of their loved ones. We collaborate and partner with other agencies, service providers and faith-based organizations to realize our shared vision for a healthy community.

Bridges Summary of our Ethical Code of Conduct

All clients of the agency's programs and services will be treated with respect for their dignity and their human rights without regard to their sex, race, age, religious beliefs, ancestry, handicapping condition, marital status, civil union status or sexual orientation. All personnel are expected to be familiar with this policy and its intent in order that they do not violate the human rights of consumers, and so they can protect and preserve the dignity and personal safety of persons served.

Please see full version of Bridges Ethics Policy posted in wait areas for further detail.

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GENERAL GUIDELINES/EXPECTATIONS

Bridges strives to provide quality services in a pleasant and safe environment.
In order to assure this, we ask your full cooperation and help with the following:

WHAT YOU CAN EXPECT OF US

- We will listen to you and respect your right to tell staff what is working for you or what is not working.
- We will work with you to achieve goals on the treatment plan by identifying actions to be taken by us and by you.
- We will respect your confidentiality.
- We will respect your right to self-determination.
- We will follow ethical and professional guidelines in our work with you.
- We will be sensitive to your individual strengths, needs, desires, goals and culture.
- We will treat you with dignity and respect.

WHAT WE EXPECT OF YOU

- No weapons are permitted on the premises.
- Everyone should talk and/or communicate in a manner that is respectful to all persons around them.
- While waiting for an appointment everyone must wait in our waiting rooms. If you find yourself waiting for more than ten minutes, please check with the receptionist to assure your clinician is aware of your arrival. In rare instances, your appointment may be delayed or cancelled due to an emergency.
- Payment is expected at time of visit at the front desk area. If you are unable to pay your copay, please ask to speak to one of our billing staff.
- If you miss two (2) consecutive scheduled appointments (including coming to treatment under the influence), you will not be scheduled again for an appointment and/or be discharged from treatment, unless discussed with staff.
- In the event that an out of control situation occurs, we will ask that the disruptive individual leave our premises and if appropriate, staff will call emergency personnel, including the police.
- Anyone found to have alcohol on their breath may be tested, and may not be allowed to drive and, in some circumstances, will not be allowed to walk home.
- We do not conduct appointments or provide services to anyone under the influence of alcohol or illegal drugs.
- Immediate action will be taken when verbal or physical threats are made against staff or clients.
- All Bridges facilities are non-smoking environments including the front steps and ramps to the main building. Our non-smoking policy is strictly enforced.
- No solicitation is allowed in or around the building.
- In case of an emergency in the building follow instructions provided over the loud speakers and by staff. Evacuation diagrams are throughout the building.

WHAT WE EXPECT OF YOU AND YOUR CHILD/REN

- It is required that parents of minor children supervise and discipline their children and remain in the building during appointment time, despite support staff supervision of child and family wait area.
- If child becomes out of control, it is also expected that parent will restrain the child, while staff contact emergency personnel, if needed.

HOURS OF OPERATION

Monday	8:00 a.m. – 7:00 p.m.
Tuesday	8:00 a.m. – 8:00 p.m.
Wednesday	8:00 a.m. – 8:00 p.m.
Thursday	8:00 a.m. – 8:00 p.m.
Friday	8:00 a.m. – 5:00 p.m.

24 HOUR ACCESS

If you have an emergency after hours (including weekends and holidays), call Bridges general number at 203-878-6365 and you will be connected to the South Central Crisis Service.

This service is staffed by professionals trained to provide crisis intervention in emergency situations, such as suicide, homicide, adverse medication reactions and any unforeseen events that have created extreme stress. They will return your call in a confidential manner as quickly as possible.

If your need is not an emergency and you want to speak to someone after hours to deal with loneliness, fears, or talking out a problem, call the Safe Harbor Warm-line at 1-800-258-1528.

This service is staffed by trained consumer volunteers.

If you are experiencing difficulty during the week, contact your clinician during work hours. This way, you and your clinician can agree on coping mechanisms that may help you through a weekend or holiday. It is also a good idea to check your medication supply prior to the weekend or holidays so you can be sure to have enough.

Remember, the staff that knows you best are the best persons to help you through difficult times. **Bridges clinicians and others are expected to return telephone calls within 24 hours or as indicated in their voice mail message.**

Other supports that can be reached after hours include:

12 Step Programs Contact Numbers:

Alcoholic Anonymous	New Haven:	1-866-783-7712
Al-Anon & Alateen	CT Info Number:	1-888-825-2666
Narcotics Anonymous	CT Region	1-800-627-3543

You can list specific numbers that apply to you and your needs:

_____

_____

_____

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.

Important Notice of Privacy Practices

Bridges... A Community Support System, Inc.

It is important to read and understand this Notice of Privacy Practices before signing the Consent and Acknowledgment Form.

Notice of Privacy Practices
Effective Date: April 14, 2003 and Revised February 17, 2010 and Revised September 23, 2013

Bridges is required by law to maintain the privacy of your health information and to provide you with this detailed Notice of our legal duties and privacy practices with respect to your health information. .Bridges shall abide by the terms of the Notice that are currently in effect. However, Bridges reserves the right to change the terms of this Notice and to make the new provisions effective for all personal health information received and maintained by Bridges now and in the future. We will provide you with a copy of the revised Notice upon request. In addition, a copy of the effective notice will be posted at all times in wait areas with a date notifying you of most recent update.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

As a client of Bridges, information about you must be used and disclosed to other parties for purpose of treatment, payment and health care operations. These uses and disclosures do not require your consent:

- **For Treatment** - We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by our staff as well as to any other health care provider involved in your care, either within Bridges or an outside healthcare provider. For example, we disclose information about your health condition to a referring physician, a pharmacist who needs the information to dispense a prescription or a laboratory that requires it to perform testing.
- **For Payment -** We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid, or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request approval for services that will be provided to you.
- **For Health Care Operations -** We may use and disclose your health information as necessary for health care operations such as management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to past, present or future medical providers for same purpose, for health care fraud and abuse detection or compliance activities. For example, health information of many clients may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

- **Individuals Involved in Your Care or Payment of Your Care.** Unless you object, we may disclose your protected health information to a family member, a relative, a close personal friend or other person you identify, including clergy, who is involved in your care.
- **Emergencies.** We may use or disclose your health information as necessary in emergency treatment situations.
- **As Required By Law.** We may use or disclose your health information when required by law to do so.
- **Business Associate.** We may disclose your personal health information to a contractor or business associate who needs the information to perform services for Bridges. To protect your health information, we have our business associates sign written contracts that require them to keep your information confidential. For example, our computer software company may have access to certain personal health information, but is required by law and our contract with them to keep the information confidential and not use it.
- **Public Health Activities**. We may disclose your **he**alth information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury, or disability; reporting to the Federal Drug Administration issues concerning problems with products or recalls or reporting births and deaths.
- **Reporting Victims of Abuse, neglect or Domestic Violence**. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use or disclose your health information to notify a government authority, if authorized by law, or if you agree to the report.

- **Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, accreditation, and licensure actions or for activities involving government oversight or the health care system.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your health information to prevent a serious threat to your health or safety or the health or safety of others limiting disclosures, to someone able to help lessen or prevent the threatened harm.
- **Judicial and Administrative Proceedings.** We may disclose your health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process if we are authorized to do so under the law
- **Law Enforcement.** We may disclose your health information for certain law enforcement purposes including, for example, to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.
- **Research.** We may use or disclose your health information for research purposes, if the privacy aspects of the research has been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.
- **Judicial and Administrative Proceedings.** We may disclose your health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process if we are authorized to do so under the law
- **Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.** We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissues.
- **Disaster Relief.** We may disclose health information about you to a disaster relief organization.
- **Military, Veterans and other Specific Government Functions.** If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities or for purpose of determining eligibility for benefits by the Department of Veterans Affairs. We may disclose your health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.
- **Benefit Programs.** We may use or disclose your health information to comply with laws and obligations relating to workers' compensation or other similar State or Federal benefit programs.
- **Inmates/Law Enforcement Custody.** If you are under custody of a law enforcement official or correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.
- **Fundraising Activities.** We may use certain limited information to contact you in an effort to raise funds for Bridges and its operations. However, you may opt-out from receiving such communications.
- **Treatment Alternatives and Health-Related Benefits and Services.** We may use or disclosed health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you and that are offered by Bridges or its affiliates and its contracted partners, including Communicare and Genoa Pharmacy.
- **Appointment Reminders** - We may use and disclose health information to remind you of appointments within our agency.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Most uses and disclosures of psychotherapy notes and of personal health information for marketing purposes and the sale of personal health information require an individual's authorization. Bridges will not be selling your personal health information at any time. Uses and disclosures not described in this Notice will be made only with your Authorization. You may revoke an Authorization in writing at any time. If you revoke an authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to Bridges by you. At your request, Bridges will supply you with the appropriate form to complete, if you wish.

Request Restrictions - You have the right to request certain restrictions on our use or disclosure of your health information for treatment, payment and health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care. We are not required to agree to your requested restriction (except if you restrict disclosures to family members or friends other than a conservator or listed health care agent). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment or in accordance with applicable law. However, you have the right to restrict certain disclosures of personal health information to a health insurance payor where the disclosure is for payment or health care operations and pertains to a health care item or service for which you (or any person other than the health insurance payor) have paid for the treatment in full.

Access to Personal Health Information - You have the right to request copies of your personal health information in any form you choose, provided that your personal health information is readily producible in that format. You have the right to request your personal health information electronically or have it directly transmitted to a third party specified by you per our capabilities. Your request must be made in writing. In most cases we may charge a reasonable cost-based fee for preparing the copy, which will not exceed our labor costs in responding to your request and postage, if applicable. We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to the health information, in some cases you have the right to request review of the denial. This review would be performed by a licensed health care professional designated by Bridges who did not participate in the decision to deny.

Request Amendment - You have the right to request an amendment to your health information maintained by Bridges for as long as the information is kept by or for Bridges. Your request must be made in writing and must state the reason for the requested amendment. We may deny your request for amendment, if the information (a) was not created by Bridges, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for Bridges; (c) is not part of the information to which you have the right of access; or (d) is already accurate and complete, as determined by Bridges.

Request an Accounting of Disclosures– You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by Bridges or by other on our behalf. This includes disclosures made for treatment, payment and health care operations if the disclosures are made through an electronic health record. To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six years from the date of your request. The first accounting provided within a twelve-month period will be free; for further requests, we may charge you our costs.

Request A Paper Copy of This Notice - You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice on our web site, www.bridgesmilford.org.

Request Confidential Communications - You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

Notification of Breach of Security. You have the right to be notified of an unauthorized disclosure of your unsecured personal health information and we will notify you of such a breach in accordance with our obligations under the law

Connecticut Only Requirement

V. SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE AND HIV-RELATED INFORMATION

For disclosures concerning health information related to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions may apply. Except as provided below and as specifically permitted or required under state or federal law, health information relating to care for psychiatric conditions, substance abuse or HIV-related information may not be disclosed with our your special authorization.

- Psychiatric information. If needed for your diagnosis or treatment at Bridges, psychiatric information may be disclosed between your treatment team members. Certain limited information may be disclosed for payment purposes
- HIV related information. Under limited circumstances, HIV-related information may be disclosed for purposes of treatment or payment.
- Substance abuse treatment. If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures, not including emergencies.

VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights or wish to make any requests, opt-out of receiving certain communications or object to a disclosure, please contact **Terri Eblen, Privacy Officer at 203-878-6365 x 311.**

If you believe your rights have been violated, you may file a complaint in writing with Bridges or with the Office for Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaint may also be made by phone to 1-877-696-6775. We will not retaliate against you if you file a complaint.

SHORT VERSION* OF BRIDGES NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

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

Bridges is required by law to maintain the privacy of your health information and to provide you with this detailed Notice of our legal duties and privacy practices with respect to your health information. .Bridges shall abide by the terms of the Notice that are currently in effect. However, Bridges reserves the right to change the terms of this Notice and to make the new provisions effective for all personal health information received and maintained by Bridges now and in the future. We will provide you with a copy of the revised Notice upon request. In addition, a copy of the effective notice will be posted at all times in wait areas with a date notifying you of most recent update.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

As a client of Bridges, information about you must be used and disclosed to other parties for purpose of treatment, payment and health care operations. These uses and disclosures do not require your consent:

- **For Treatment** - We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by our staff as well as to any other health care provider involved in your care, either within Bridges or an outside healthcare provider. For example, we disclose information about your health condition to a referring physician, a pharmacist who needs the information to dispense a prescription or a laboratory that requires it to perform testing.
- **For Payment -** We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid, or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request approval for services that will be provided to you.
- **For Health Care Operations -** We may use and disclose your health information as necessary for health care operations such as management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to past, present or future medical providers for same purpose, for health care fraud and abuse detection or compliance activities. For example, health information of many clients may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information for which you are consenting or as required by law or as allowed by HIPAA.

Individuals Involved in Your Care or Payment of Your Care, Emergencies, As Required By Law, Business Associate, Public Health Activities, Reporting Victims of Abuse, Neglect or Domestic Violence, Health Oversight Activities, To Avert a Serious Threat to Health or Safety, Judicial and Administrative Proceedings, Law Enforcement, Research, Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations, Disaster Relief, Military, Veterans and other Specific Government Functions, Workers' Compensation and other Benefit Programs, Inmates/Law Enforcement Custody, and Appointment Reminders.

- **Fundraising Activities.** We may use certain limited information to contact you in an effort to raise funds for Bridges and its operations. However, you may opt-out from receiving such communications.
- **Treatment Alternatives and Health-Related Benefits and Services.** We may use or disclosed health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you and that are offered by Bridges or its affiliates and its contracted partners, including Communicare and Genoa Pharmacy.
- **Appointment Reminders -** We may use and disclose health information to remind you of appointments within our agency.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Most uses and disclosures of psychotherapy notes and of personal health information for marketing purposes and the sale of personal health information require an individual's authorization. Bridges will not be selling your personal health information at any time. Uses and disclosures not described in this Notice will be made only with your Authorization. You may revoke an Authorization in writing at any time. If you revoke an authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to Bridges by you. At your request, Bridges will supply you with the appropriate form to complete, if you wish.

Request Restrictions - You have the right to request certain restrictions on our use or disclosure of your health information for treatment, payment and health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care. We are not required to agree to your requested restriction (except if you restrict disclosures to family members or friends other than a conservator or listed health care agent). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment or in accordance with applicable law. However, you have the right to restrict certain disclosures of personal health information to a health insurance payor where the disclosure is for payment or health care operations and pertains to a health care item or service for which you (or any person other than the health insurance payor) have paid for the treatment in full.

Access to Personal Health Information - You have the right to request copies of your personal health information in any form you choose, provided that your personal health information is readily producible in that format. You have the right to request your personal health information electronically or have it directly transmitted to a third party specified by you per our capabilities. Your request must be made in writing. In most cases we may charge a reasonable cost-based fee for preparing the copy, which will not exceed our labor costs in responding to your request and postage, if applicable. We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to the health information, in some cases you have the right to request review of the denial. This review would be performed by a licensed health care professional designated by Bridges who did not participate in the decision to deny.

Request Amendment - You have the right to request an amendment to your health information maintained by Bridges for as long as the information is kept by or for Bridges. Your request must be made in writing and must state the reason for the requested amendment. We may deny your request for amendment, if the information (a) was not created by Bridges, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for Bridges; (c) is not part of the information to which you have the right of access; or (d) is already accurate and complete, as determined by Bridges.

Request an Accounting of Disclosures– You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by Bridges or by other on our behalf. This includes disclosures made for treatment, payment and health care operations if the disclosures are made through an electronic health record. To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six years from the date of your request. The first accounting provided within a twelve-month period will be free; for further requests, we may charge you our costs.

Request A Paper Copy of This Notice - You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice on our web site, www.bridgesmilford.org.

Request Confidential Communications - You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

Notification of Breach of Security. You have the right to be notified of an unauthorized disclosure of your unsecured personal health information and we will notify you of such a breach in accordance with our obligations under the law

V. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights or wish to make any requests, opt-out of receiving certain communications or object to a disclosure, please contact **Terri Eblen, Privacy Officer at 203-878-6365 x 311.**

If you believe your rights have been violated, you may file a complaint in writing with Bridges or with the Office for Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaint may also be made by phone to 1-877-696-6775. We will not retaliate against you if you file a complaint.

I acknowledge that I have read or had this Notice explained to me. I understand this Notice and have had the opportunity to ask questions regarding any matters of concern and signing it voluntarily.

_____ _____

Print Name of Individual or Personal Representative Signature of Individual or Personal Representative

Date: _____

****

FOR OFFICE USE ONLY: Unable to obtain written consent and acknowledgment because: □ Individual refused

□ Emergency treatment situation □ Individual not able to sign due to incompetence or other medical reason

□ Other: _____ Initials of person witnessing signature:

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RIGHTS & RESPONSIBILITIES OF CLIENTS

Bridges...A Community Support System will follow the statutes of the State of Connecticut, Section 17a-540(formerly Sec. 17-206a) to 17a-550 (formerly Sec.17-206k), that outline rights of clients at facilities such as Bridges...A Community Support System. These rights include:

1. The right to be treated with respect and dignity.

2. The right of privacy and maintenance of confidentiality.

3. The right to participate in voluntary treatment, the right for a specialized treatment plan and the right to refuse treatment recommended by the staff.

4. The right to seek a psychiatric consultation or the right to refuse such a recommendation. In addition, clients may refuse to take medication recommended by a psychiatrist. . If client chooses to receive medication, it will only be with informed consent.

5. The right to receive treatment that is based upon a sliding fee scale determined by the client's income.

6. The right to treatment regardless of race, religion, national origin, age, sex or other attributes.

7. The right to access the grievance procedure if a client feels any of the above rights were violated. If this process does not remedy the situation, the client has the right to formal legal action.

In addition to the statues above, clients' rights include protection from abuse, financial or other exploitation, retaliation, humiliation and neglect.
Any client believing that his or her rights have not been fully considered may use the grievance procedures outlined on the next page. Agency Ethics and Grievance Policies are posted in our waiting rooms.

I HEREBY CONSENT TO TREATMENT and I agree to participate in my treatment, which may consist of one or more of the following: ☐ Assessment ☐ Individual ☐ Family ☐ Marital/Couples ☐ Group ☐ Psychiatric Evaluation/Medication Management ☐ CS Services
☐ Other: please describe: _____
Other details of my treatment contract are indicated on the treatment plan addendum.

IN ADDITION, MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTOOD:

1. **Rights and responsibilities described above;**
2. **General Guidelines provided in Welcome Packet;**
3. **Confidentiality regulations (described on other side of this form);**
4. **Grievance procedures (described on other side of this form); and**
5. **Fire and Emergency procedures (described on other side of form)**

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Personal Representative Date

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CONFIDENTIALITY PROCEDURES

The Bridges...A Community Support System adheres to State and Federal regulations of confidentiality. The agency will not give out any information to anyone without your written authorization, except under the following circumstances:

- Your clinician could be subpoenaed to testify about you in court.
- If you indicate that you intend to harm someone or yourself, the agency is required to take action to prevent that harm from occurring, including alerting the authorities and alerting the person being threatened.
- The agency is also required to report any suspected child/elderly abuse or neglect and in an emergency situation to another provider in the support of the development of a crisis stabilization plan.
- In event of a crime committed on program premises, or against program personnel or threats to do so.

CONSUMER INPUT, including Permission to Receive Follow-Up Call

Bridges is committed to the full inclusion of consumers in the design, implementation, modification, and evaluation of its programs and services. All persons served by the agency will have the opportunity to participate in these activities, and to express their satisfaction with the services they receive. Please ask your service provider about our Consumer Advisory Committee, scheduled Client Satisfaction Surveys, location of Client Suggestion Boxes, and other ways to gather your feedback. YOUR OPINION MATTERS to us!

In addition, it is agency policy to call our clients approximately three months after discharge from the agency. We do this to ask you how you are doing and to give you an opportunity to provide us with feedback about the services you received at the agency. If you agree to such a call, please initial here: _____.

GRIEVANCE/COMPLAINT PROCEDURES

If you have a grievance or concern, you should follow these steps:

1. State your concerns to the staff member providing services to you.
2. If not resolved, you may request to speak to that person's supervisor.
3. If not resolved at that level, you may file a written grievance with the Consumer Rights Officer.

All grievances regarding client's rights should be put in writing (complaint forms are available from the receptionist). All communications will be kept confidential.
The Clinic's policies regarding client grievance procedures are available upon request.

FIRE / EMERGENCY& MEDICAL EMERGENCY PROCEDURES

1. In the event of a fire or emergency, audible fire alarms and a recorded voice evacuation message will be heard on both the lower and upper floors.
2. Check the Fire Emergency Exit Plans posted on the wall in the waiting room and **EXIT** the building **IMMEDIATELY**, using the routes outlined in those plans.
3. If you are waiting for a child who is being seen by a staff member in an office at the time of a fire emergency, **DO NOT** attempt to go to the office to get the child. **EXIT** the building immediately and assemble in the front of the building. All staff are responsible for getting their clients out of the building, including children. No matter what exit route they use to do so, they will all assemble in the front of the building.
4. Administration of first aid to children is the responsibility of the parent/guardian. Staff that are providing services to child will direct parent/guardian to location of first aid box as indicated above. If the parent/guardian of the child is unavailable, the staff providing services will administer first aid and if necessary follow Medical Emergency policy/procedures posted.

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VOTER REGISTRATION INFORMATION

(Form required due to receiving partial public funding)

Declining To Register To Vote – By Mail (P.A. 94-121 Rev. 10/31/94)

If you are not registered to vote where you live now, would you like to apply to register to vote today? Yes □ No □ Currently Registered to Vote □

IF YOU DO NOT CHECK ANY BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the enclosed voter registration application form, we will help you. Call your worker. If you fill out and sign the voter registration application, mail it to us in the enclosed envelope or mail it directly to the registrars of voters in your Town Hall.

Declining to register to vote and the particular office at which you register to vote remain confidential and will be used only for voter registration purposes.

_____ _____ _____

Name Signature Date

(for agency use only)

Voter Registration Form Completed: YES _____ NO _____

_____ _____

Agency Staff Signature Date

Staff will mail completed top portion to State Elections Commission. A copy will be made for client to keep for their records and to reference information below if needed.

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Elections Enforcement Commission
410 Asylum Street, Room 513
Hartford, CT 06103

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GOALS FOR SERVICE PLANNING

This form is optional to complete; however, it is helpful in getting your words as to how we may best meet your needs. If you chose to not complete this now, please indicate that below and sign your name.)

NAME: _____

1. What are your reasons for coming to Bridges...A Community Support System?

   _____
   _____
   _____

2. How have the above caused problems in your life?

   _____
   _____
   _____

3. Do you need help with other concern/problems or have any special needs or accommodations? (These may include assistance with walking, vision, hearing and/or reading.)

   _____
   _____

4. What are your expectations for your child/family member during the assessment and initial treatment?

   _____
   _____

5. What do you hope to gain from coming to Bridges or being in therapy? How can we assist you in reaching your hopes, dreams, preferences, etc.?

   _____
   _____

6. How will you know when your goals are met (that is, when you would be ready to decrease your sessions or stop therapy altogether)?

   _____
   _____

7. Please indicate the name, address and telephone number of your primary care physician:
   Name: _____

   Address: _____ Telephone #: _____

8. Please indicate current emergency contact: Name/Relationship: _____
   Telephone #: _____

9. What times (day of week, morning, afternoon, evening) are you available for appointments?

   _____

_____ _____
Name Date

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ORIENTATION CHECKLISTS

CLIENT NAME: _____

INTAKE/ASSESSMENT Reviewed by Reception/Welcoming Staff	**Staff Initials**	**Date**
Financial Agreement (copy to client)		
Rights & Responsibilities (copy to client)		
General Guidelines (copy to client)		
Notice of Privacy Practices Consent/Acknowledgment Form (give to client)		
24 Hour Crisis Service		
Voter Registration		
Service/Treatment Goals		
I have received a copy of my financial agreement, Client Rights & Responsibilities, General Guidelines and Notice of Privacy Practices. _____ _____ Client Signature Date _____ _____ Front Desk/Billing Staff Signature Date		
ADMISSION Reviewed by provider when services start after intake	**Staff Initials**	**Date**
24 HR Crisis Service		
Grievance Procedure – explained to client/child, parent/guardian		
Program Specific Information - includes services/interventions available; program rules and what behaviors would prompt restriction of rights/privileges and how to regain rights		
Goals for Service/Treatment Planning		
Treatment Contract • If minor, review arrival and departure arrangements		
Confidentiality Regulations – reference Mandated Reporter requirements (Sec 17a-101 CGS)		
Transition/Recovery Process • Indicate by circling **Yes** or **No**, if want discharge summary mailed if unable to receive at discharge		
Aftercare/follow-up		

The above policies and procedures have been discussed with me and I understand how they impact my service(s) at Bridges.

_____ _____ _____
Client Signature Parent/Guardian Signature Date

_____ _____
Primary Staff Signature Date

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FINANCIAL AGREEMENT

Client Name: _____

1. As an insured client, I understand that Bridges...A Community Support System, Inc. will charge me my copayment established by my insurance policy. If I elect to change insurance coverage or copayment during my course of treatment, Bridges will automatically use my updated copayment.

2. If I have no insurance, Bridges will use my documented income to set a sliding fee payment. Based upon this, my sliding fee payment for the following typical services that I might receive at Bridges will be:

SERVICE	FULL FEE	CO-PAYMENT
Intake/Consultation	$275	
1½ Hour Therapy	$225	
1 Hour Therapy	$150	
½ Hour Therapy	$ 75	
Group Session	$100	
Medication Evaluation	$325	
½ Hour Medication Clinic	$175	
¼ Hour Medication Clinic (Adult)	$ 90	
1 Hour Play Therapy (Child)	$175	
½ Hour Play Therapy (Child)	$ 90	

3. I understand, for uninsured clients, that Bridges' ability to maintain the above sliding fee schedule is based on its receiving local and state funds, and grants that support the services.

4. If I am/become uninsured, I understand that I must provide proof of income to determine appropriate copayment. If I fail to provide the requested proof of income, I will assume responsibility for payment of the **FULL FEE** for any services provided to me. This **FULL FEE** will be charged to me until such time that I do provide Bridges with the required documented proof of my income.

5. I understand that if my Medicaid or Husky insurance becomes ineligible, **I will be charged a 10% co pay for the above listed services not paid by Medicaid or Husky.** Initial: _____

6. I understand that I must keep Bridges informed of any changes to my insurance status or coverage. Therefore, **I agree to be financially responsible for any charges not reimbursed by my insurance carrier due to the fact that I did not notify Bridges of any change in my insurance status or coverage.**
Initial: _____

7. I understand that I am financially responsible for payment of any insurance deductible as required under my insurance policy during each calendar year. Bridges has been quoted $_____. If the amount changes under my policy, Bridges will use the most current deductible amount as quoted by my insurance company. Initial: _____

8. I understand that if I receive an insurance check for services I have received at Bridges, I am required to endorse the check over to Bridges. I understand that failure to comply with the above may constitute insurance fraud and will be immediately referred to a collection agency.

9. I understand that my co-payment **MUST BE PAID** at the time of service.

10. I understand that I must give Bridges at least 24 hour notice for canceled appointments. Failure to give proper notice may result in a charge to me.

11. I agree that I am financially responsible for my balance. I will keep current with my payments or contact the Billing Department **in advance of my appointment** to make payment arrangements.

12. I understand that Bridges has the right to turn my account over to a collection agency after been mailed 3 billing statements and a collection letter.

STATEMENT OF ASSIGNMENT AND RELEASE

I authorize the release of any medical or other information necessary to process all claims I may incur for services provided at Bridges.

I authorize payment of benefits to Bridges for services rendered.

I understand that services provided at Bridges...A Community Support System, Inc., are partially subsidized by the State of Connecticut Department of Mental Health and Addictions Services, or the Department of Children and Families and that information regarding services is provided to the responsible funding agency.

_____ _____

Signature of Client/Responsible Person Date

_____ _____

Bridges Authorized Signature Date