Impact Group BHS

9428 Brookshire Ave Suite 2

Baton Rouge, Louisiana 70809

(0)225-372-2693

IMPACT GROUP
BEHAVIOURAL HEALTH SERVICES

Please download form and fill out the questions once completed click submit and close the application.

Intake Form

DEMOGRAPHIC:

Client Name: _____ **DOB:** _____ **Age:** _____

Sex: ☐ Female ☐ Male **Race:** Black or African American

Sexual Orientation: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Not Applicable Due to Age

☐ Questioning ☐ Decline to Answer

Marital Status: ☐Single ☐ Married ☐ Divorce ☐ Widow

Ethnicity: Hispanic ☐ Non- Hispanic ☐

Activate Military: ☐ Yes ☐ No

Veteran ☐ Yes ☐ No If yes, how many years were you active? _____

Religion _____

Insurance Provider Name: _____ **Insurance ID:** _____

Ins Type: ☐ Private ☐ Medicare ☐ None

SS #: _____

CONTACT INFORMATION:

Phone Number: _____ **Alternate Phone:** _____

Address: (No PO Box): _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Care Physician Name and Address: _____

_____

Do you give IGBHS permission to inform your PCP that services are provided? ☐ Yes ☐ No

Currently Employed: ☐ Yes ☐ No **Employer Name:** _____

Highest Form of Education: ☐ NA ☐ Elem ☐ HS ☐ Assoc ☐ BS ☐ MA ☐ Doc

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Education: Is the client enrolled in school? ☐ Yes ☐No If yes, Grade/YR in college _____

School Name: _____

If Acceptable, do you give IGBHS permission to inform your child's school that services are provided/intact?

☐ Yes ☐No

Are you able to read and write? ☐ Yes ☐ No

Are you Currently Pregnant or believe you may be pregnant? ☐ Yes ☐ No

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Emergency Contact Form

Recipient's Name: _____

Parent/Legal Guardian: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

If in the event Impact Group BHS is unable to contact you at the above information, who may we contact and leave a message with?

Emergency Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

PCP INFORMATION

Doctor's Name or Clinic: _____

Address: _____

Phone: _____ Fax: _____

Is there anyone else you would like to add as an emergency contact?

Additional Contact: _____

_____

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GRIEVANCE ACKNOWLEDGEMENT

When clients of Impact Group BHS have a grievance concerning the rehabilitation services that they are receiving, they may request in writing a meeting with the Clinical Manager.

By signing below, I acknowledge I am aware and understand

Impact Group BHS, *Grievance Policy*

Client Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

I certify that I have explained all rights and responsibilities to client:

Staff Signature: _____ Date: _____

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CRISIS RESPONSE PLAN ACKNOWLEDGEMENT

I _____ , do acknowledge that I am aware and understand Impact Group BHS's 24 Hour Crisis Response Plan.

Recipient's Name:_____

Print

Recipient's Signature: _____ Date: _____

Parent/Guardian if client is under 18

Staff Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

By signing below, I acknowledge I have received a copy of Impact Group BHS "Notice of Privacy Practices"

Client's Name: _____

Client's Signature: _____ Date: _____

Parent/Guardian if client is under 18

Staff Signature: _____ Date: _____

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ORIENTATION ACKNOWLEDGEMENT

By signing below, I acknowledge I have received a copy of Impact Group BHS Recipient Handbook.

Recipient's Name: _____ Date of Birth: _____

Recipient's Signature: _____ Date: _____

Parent/Guardian if client is under 18

I certify that I have explained all **Impact Group BHS** Policies and Procedures, Rights and Responsibilities to the client:

Staff Signature: _____ Date: _____

(Orientation Acknowledgement)

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MEMBER'S CHOICE IN PROVIDER FORM

Member Name: _____

Member Date of Birth: _____ Member ID: _____

Impact Group Behavioral Health Services provides holistic health and human services across the continuum of care by providing community based services and crisis interventions to restore individuals back to functioning.

The provider I choose is:

Provider Name: _____ Provider Phone: _____

By signing below, I acknowledge that I freely choose to receive services from the above provider and I acknowledge my responsibility to notify my previous provider in order to coordinate care.

Member/Legal Guardian Signature: _____ Date: _____

Legal Guardian Name (If applicable): _____

Providers: A Choice in Provider Form is required prior to service authorizations. The form requires a member/legal guardian signature, date, and identified provider with telephone number. The provider is responsible for coordination care with the member's prior provider.

Provider Signature: _____ Date: _____

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AUTHORIZATION FOR OUTPATIENT TREATMENT

I _____, do hereby authorize Impact Group BHS it's consultants, therapists, medical staff employees, and whomever else may be necessary to administer outpatient therapy and or procedures that are considered necessary for my treatment.

I understand that various procedures and treatments may be used, and that liability of Impact Group BHS and its employees are limited only to negligence.

The services provided are as follows:

_____ Assessment

_____ Education

_____ Psychiatric Evaluation

_____ Home and Community Based

_____ Group Counseling

____ Family Counseling

_____ Medication Management

_____ Assertive Community Treatment

_____ Substance-IOP

I furthermore, give Impact Group BHS staff to provide Emergency Medical Treatment if needed.

***Please Sign and Date**

Client Name: _____

Client Signature: _____ Date: _____

Parent/Guardian if client is under 18

Staff Signature: _____ Date: _____

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AUTHORIZATION FOR SCHOOL VISITS

I _____ , the parent/guardian of _____

Give Impact Group BHS staff member(s) permission to visit with my child at school for services including but not limited to:

- Psychosocial skills training
- Service Integration (Observation and Redirection of off-task behaviors)

My child attends _____ and is in the

_____ grade.

My child's teacher's/teachers' name(s):

_____

_____

_____

_____ _____

Parent/ Guardian Signature Date

_____ _____

Impact Group BHS Authorized Staff Date

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INFORMED CONSENT FOR MEDICINE

I have the right to refuse medicine, and it cannot be given to me until I talk with my doctor and I say I am OK with taking medicine.

My Doctor and I talked about:

1. My diagnosis
2. The reason my doctor wants me to take the medicine, and the change of me getting better – or not getting better -without the medicine.
3. The fact that I can say NO to the medicine at any time, but I have to tell my doctor.
4. Any other ways to treat my problems.
5. The medicine that I will be taking – the does, when and how I will take it, and about how long I will need to take it.
6. The side effects for the medicine and any that might be likely in my case – Some medicines may start to hurt my body after I begin taking them, so I may need to have lab tests to make sure I am safe with these medicines. My doctor will take with me about this if I am taking one of these medicines.

I will talk with my doctor about all my medical problems and any medicine that I am already taking.

Medicine prescribed today by my doctor: Medicine Name, Dose, When, How

Medicine Name	Dose	When	How

I, _____ I refuse medicine at this time.

I, _____ I consent to the medicine and will take as the doctor says.

_____ _____

Client Name Signature Date

_____ _____

Client Guardian Signature Date

_____ _____

Prescribing Provider Date

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2018-2019

Reciprocal Release of Information/Permission to Allow Services During the Instructional Day

This release authorizes East Baton Rouge Parish School System to release to:

Name: _____

Address: _____

City, State, Zip: _____

Agency Name: _____

and

This release authorizes the above to release to:

The East Baton Rouge Parish School System

1050 South Foster Dr.

Baton Rouge, LA 70806

Information as described below pertinent to:

_____ _____

Student's Name Date of Birth

This agreement will permit the release of the following information to the outside agency providing services on EBRPSS campuses: student name, address, date of birth, grades, attendance records, disciplinary records, testing/assessments and reports, IEP and 504 Plans, and other educationally relevant information pertinent to the services provided.

This information is requested to allow for collaboration between educational and mental health service providers and will not be released to any further source or used for any reason other than the purpose stated above.

Your signature below provides for the release of this information and grants permission to the school to allow your child to receive these services during the instructional day. It is understood that all missed work must be completed and that service must be scheduled so as to minimize the effect on academics. The scheduling of these services is at the principal's discretion.

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This authorization is effective form the date of the appended signature and will remain effect for (1) calendar year. Authorization is subject to written revocation at any time except to the extent that action has already been take in reliance upon this document.

Signature of Parent/Guardian

Date of Signature

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EMERGENCY PREPAREDNESS QUESTIONAIRE

Please provide us with your updated emergency contact information and contact information of your evacuation destination.

Client Name:	Emergency Contact:
Address:	Address:
Phone:	Phone:

Do you have somewhere to evacuate? ☐ Yes ☐ No

Do you plane to evacuate? ☐ Yes ☐ No

If so, when? _____

Do you plan to return? ☐ Yes ☐ No

Who will evacuate with you?

_____

_____

Do you have the necessities to evacuate? ☐ Yes ☐ No

Do you currently own a cell phone? ☐ Yes ☐ No

If not, whom can we contact to immediately reach you?

_____

_____

What is the best way to contact you? ☐ Phone ☐ Text ☐ Email ☐ All Three

Any additional comments/information:

_____

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PRESENTING PROBMEM(s): Please check all that apply

☐ Anxiety ☐ Criminal behavior (such as stealing, breaking into house and vandalism) ☐ Constant restlessness ☐ Cutting Self ☐ Defiance (not wanting to do what they are told) ☐ Depression ☐ Lack of Focus ☐ History of Trauma ☐ Witnessed Trauma ☐ Abuse ☐ Neglect ☐ Sexual Assault ☐ Body Aches ☐ Flu ☐ Heart Failure ☐ Pain ☐ Chronic Pain ☐ Destructiveness (e.g., destroying property) ☐ Difficulty concentrating ☐ Substance ☐ Probation	☐ Fidgety ☐ Fighting ☐ Fire-setting ☐ Forgetting instructions ☐ Hitting or biting themselves ☐ Hurting pets or other animals ☐ Low self-esteem ☐ Lying	☐ Phobias ☐ Running away ☐ Suicidal ☐ Talking back or arguing with parent ☐ Temper tantrums ☐ Verbally threating others

Past Treatment:

Has the client been diagnosed with behavioral or mental disorder in the past? ☐ Yes ☐ No

If "Yes", what diagnoses was given?

Was the client prescribed any medication for this diagnosis? ☐ Yes ☐ No If "Yes" what medication(s) were prescribed?

Has the client ever been enrolled in another agency/program? ☐ Yes ☐ No If "Yes" where?

Was services completed? ☐ Yes ☐ No

Referral Source: _____

Assessment Appointment

Date: _____ at _____

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Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid # or Social Security #

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

☐ TO RELEASE Information TO OR ☐ TO OBTAIN Information FROM

(Place and "X" in the box that indicates if the information is being released OR requested.)

Name:

Mailing Address:

City, State, Zip Code: _____

Relationship: _____ Telephone _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians

☐ Research related treatment ☐ Creating health information for disclosure to a third party.

☐ Other: (Specify) _____

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports Treatment or Tests

☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports Laboratory Reports

☐ X-ray Reports ☐ MR/DD Records ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism † ☐ Drug Abuse † ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes

☐ Other _____

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This authorization shall expire on _____ (date or event) and is needed for the period beginning _____and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____

Signature of Individual or Personal Representative Authorized by Law | Date

Please submit medical information to:

Agency Representative	Title	Date
Telephone	Fax	Email

Print Form Submit Form