2.3.7.13 SEXUAL HEALTH IN RECOVERY GROUP REGISTRATION FORM

Please Block Print Today's Date:

Legal Name:
First MI Last

Chosen/Prefered Name:

Phone:

Email:

Preferred Method of Contact: ☐ Phone ☐ Email

☐ Montrose Center client
☐ Current or Returning Montrose Center client

Group Name: _____

If you are a current or returning client who has had an intake, skip to how did you hear about this group.

Date of Birth: Age: ____

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex

Gender: ☐ cis-Male ☐ cis-Female ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine
☐ Genderqueer ☐ Non-Binary ☐ Pangender ☐ Other: _____

Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Hir/Zirs/Hirs

Orientation: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Gay/Lesbian ☐ Heterosexual/Straight ☐ Lesbian
☐ Pansexual ☐ Queer ☐ Questioning ☐ Don't Know ☐ Other: _____

Ethnicity (optional - for statistical information only):
Are you of Spanish/Latino(a) origin? ☐ yes ☐ no ☐ Decline to Answer

If yes, ☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ Puerto Rican
☐ Other/Multi Hispanic, Latino/a or Spanish origin

Race (optional - for statistical information only):
☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/PI
☐ White ☐ Other, explain: _____ ☐ Decline to Answer

If Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other/Multi Asian

How did you hear about this group? _____
Briefly describe your experience with substance use and/or addiction:

3.3.3 GROUP GUIDELINES

The following are rules that the Montrose Center recommends for use in support and therapy groups to ensure the best possible experience for all participants. These guidelines may be adapted by each program and group. Please take a moment to read the list. Your group facilitator will discuss ALL these rules with the group members. Please ask any questions that might help you understand them.

- Confidentiality is essential in order for members to feel free to open up and talk about personal and perhaps sensitive issues. Please keep the names of group participants and the disclosures they make in group confidential even after your participation in group ends.
- The group facilitator also has an obligation to keep the identity and contact information of group members and the information exchanged in group confidential. There are a few exceptions to this. Should the group facilitator become aware of child or elder abuse or threats of suicide or homicide, they will have to report the information to their supervisor, and to legal authorities.
- Group members are to be respectful of other group members at all times. Abuse or threatening behavior of any kind is inappropriate. Verbal attacks, name-calling, put-downs, and the like would be damaging to group safety, and your facilitator may ask you to leave group.
- It is not unusual to experience intense emotional feelings in a group session; if you do have strong feelings, it is important to stay in the group room and process them. If someone leaves before group is over, it may affect the safety of the member leaving as well as the members remaining. Group members are expected to participate as much as they can. However, no one will be forced to do or say anything.
- Group is held weekly from _____ to _____. It will start and stop on time. Arriving on time will help minimize disruptions.
- Attendance is an important commitment to the group. Please call prior to the group meeting if you are going to miss so the group may be informed of your absence at the beginning of the session. Please do not miss unless you are ill or have an emergency
- All members are expected to come to group free from any mind-altering substances, unless prescribed by a physician and taken as prescribed, and free from hangovers. Alcohol and drug use of any kind or amount or a hangover tends to numb or medicate feelings, which is counter to the therapeutic purpose of attending the group; intoxicated or impaired members may be asked to leave group.
- Dating or sex between group members is not allowed. Should this occur, the two people involved would be asked to decide which one would resign from the group. Significant contact between group members outside of group should be reported back to the group. Physical contact with another group member (e.g. hug) is discouraged without that member's permission.
- Audio tape recorders, cameras, video recorders or use of any of these functions on a phone are not allowed in building without the written consent of all parties to be recorded and prior written consent from the group facilitator. This is necessary to insure client and staff confidentiality and privacy. Failure to abide by this rule may result in termination of service at the Center.
- The use of tobacco products of any kind, including e-cigarettes, is not permitted anywhere on the property.
- The group guidelines have been discussed with me and I agree to follow them.

_____ _____ _____/_____/_____
Client's Name Client's Signature

Therapist's Signature: _____

1.1 STATEMENT OF CLIENT RIGHTS & RESPONSIBILITIES

RIGHTS

All applicants/clients/participants/families (client or through their surrogate) admitted to services and applicants for services of the Montrose Center shall have all the rights and responsibilities of other residents of the State of Texas and the United States of America including the following rights and responsibilities:

1. **Confidentiality:** Clients have the right to confidentiality. No information from which the identity of clients or their treatment can be determined shall be given directly or by reference to the public or any other individual or agency without the written consent of the client as governed by local, State, and Federal regulations.

   The law authorizes the Center to disclose information in the case of: (1) a court order, (2) imminent harm that might come to the client or others (child abuse, homicide, suicide, physical harm, abuse by a previous Therapist), (3) mandatory reporting for abuse or suspected abuse of children, the elderly or people with disabilities; and (4) coded intake, treatment and follow-up data (with client name removed) sent to the funding source as a requirement for sponsorship. In addition, coded data (client name removed) or aggregate data is used by the Center for the purpose of program evaluation and research. Clients have the right to be informed when information is released without permission due to the above listed exceptions.

   By appointment, clients may inspect their own clinical and financial records that are maintained by the Center, unless deemed harmful to the client. Copies can be obtained by signing a release. Copies shall be available within seven (7) calendar days of the request. There is a fee of 10¢ per page unless the copy is necessary to file or appeal a disability claim or designation.

2. **Discrimination:** Clients have the right not to be discriminated against and to receive appropriate care. No person shall be denied services in any the Center program based on their age, sex, race, ethnicity, creed, national origin, sexual/affectional orientation, gender identity or expression, physical or mental ability, religious practice or preference, HIV status, chemical dependency status, marital status, or pregnancy, although, some programs give priority to certain groups or target populations.

   No person who qualifies for grant subsidized services shall be denied services based on their ability to pay for the services.

3. **Research:** Clients have the right to refuse to participate in research without affecting access to services.

4. **Informed Consent:** Clients have the right to give informed consent or to refuse treatment and to be advised of the consequences of such a decision. Informed consent includes information about the condition to be treated; the proposed treatment; risks, side effects, and benefits of all proposed treatments; alternative treatments and which ones might be appropriate; probable physical and mental health consequences if treatment is refused; and expected length of stay. If a client is disoriented or lacks the capacity to under this at the time of admission, they are informed again when they are able to understand.

   Clients have the right to accept, refuse or withdraw from treatment after receiving the above information and to leave treatment at any time, unless otherwise prohibited by law. All services at the Center are outpatient and voluntary.

5. **Treatment/Service/Wellness Plans:** Clients have the right to actively participate in the development of an individualized treatment plan including periodic review at least once a month.

   Clients have the right not to be given medication not needed or too much medication. The Center does not prescribe or administer medications.

   Clients have the right not to be held or placed in a locked room alone unless the client is a danger to themselves or others. The Center does not use personal restraint in treatment.

   Clients have the right to participate in an client annual needs assessment and client satisfaction survey. Surveys are available in the lobby and at the reception desk throughout the year.

   Clients have the right to receive individualized services and to refuse or accept services after being informed of services and responsibilities, including: program goals and objectives, rules and regulations and client rights.

   Clients have the right to include members of the client's family of choice in treatment planning and discharge planning.

6. **Provider Information, Communication and Choice:** Clients have the right to know the identity and qualifications of the staff providing treatment and to have competent, qualified and experienced staff to supervise and carry out services. Clients have the right to know the reason for any proposed change in staff responsible for their care. Clients have the right to an explanation of any professional relationship between the Center and any other health care or educational institution involved in the client's care. Clients have a right to a second opinion.

   Clients have the right to be informed about program rules and regulations before admission.

   Clients have the right to have freedom of choice when choosing a provider of comprehensive outpatient health and psychosocial support services.

   Clients have the right to appropriate treatment in the least restrictive setting available that meets the client's needs. The Center only provides outpatient services. The right to designate a surrogate decision maker if the client is incapable of understanding a proposed course of care or is unable to communicate their wishes regarding that care.

   Clients have the right to free communication within the constraints of the individualized treatment plan with justification for any restrictions documented in the client's record. Since the Center is an outpatient facility, there are no restrictions.

   Answering Service: the Center answers the phones during normal business hours and utilizes an answering service after 7:00 pm weekdays and on weekends for emergencies.

   The Center phones and employees home phones show up as anonymous on Caller ID. If a client does not accept anonymous calls, the Center's number will appear on the Caller ID.

7. **Complaints and Grievances** (see section on complaints)**:** Clients have the right to receive a copy of the complaints procedures within 24 hours of admission. Clients have the right to a comment, complaint and grievance procedure without fear of denial of service or other punitive measures and receive a fair response from the Center within a reasonable amount of time. Complaints may be brought about any part of services including modifying, suspending or terminating service.

8. **Humane Environment, Abuse, Neglect and Exploitation:** Clients have the right to a humane environment that provides reasonable protection from harm and privacy for personal needs which is free from physical, mental or sexual abuse, neglect and exploitation.

9. **Dignity:** Clients have the right to be treated with respect, consideration and recognition of their dignity, individuality and personal privacy. Clients have the responsibility to render the same to the provider to receive personal care and treatment in safe, clean surroundings. Clients have the right to treatment, care and settings that is considerate and respectful of the client's beliefs and values.

10. **Peers serving as employees or volunteers:** Clients have the right to serve as peer support specialists as either an employee or volunteer. Clients have a right to integrate peer work into a care plan.

11. **Fees and Payments:** The right to know in advance about the cost and conditions of payment for treatment, including limitations on the duration of services.

12. **Explanation of Rights and Responsibilities:** The right to receive a complete explanation of these rights in clear, non-technical terms and in a language the client understands within 24 hours of admission.

    The right at the time of admission or at anytime upon request throughout the span of service, to have a staff member inform the client of their client rights, and to have any questions about these rights answered.

    The right to receive a written copy and explanation of these client rights and the grievance procedure at the time of admission or at anytime upon request throughout the span of service including the funding sources address and phone number.

13. **Detention:** The right not to be detained against the client/consenter's will.

14. **Conditions for Service:** The right to receive services free from conflict of interest or dual relationships. If now or at anytime while receiving services here a client is involved in a partner/spouse relationship with a staff member or member of the board of directors, services should be discontinued and three referrals will be given. Since dual relationships between clients and the Center staff and volunteers can interfere with the therapeutic process, the relationship needs to be over for at least one (1) year before services can resume.

RESPONSIBILITIES

1. **Confidentiality:** As a client you have the responsibility to never repeat to anyone else the name or identifying information of any other clients you see at the Center. All clients deserve the same privacy from each other that the staff gives you.

2. **Information:** As a client you have the responsibility to inform your Therapist or Case Manager when you do not understand instructions or information that you receive. If you need someone to help you complete forms, explain an instruction or read or interpret for you, staff needs to know that from you. As a client you have the responsibility to keep your Case Manager or Therapist informed about the quality, appropriateness and timeliness of services that you are receiving. The Center tries to provide services that fit you and your situation. If you have had problems with the services here you have options. Tell your Therapist or Case Manager, talk to their supervisor or fill out an anonymous survey in the lobby. As a client you have the responsibility to provide accurate and complete information about your history and changes in your condition during services.

3. **Appointments:** As a client you have the responsibility to keep your scheduled appointments with your Therapist or Case Manager and other service providers and to notify them when you need to cancel or reschedule. All counseling services are scheduled by appointment only. If you cannot get to your appointment, please call at least 24 hours in advance. In emergencies, call as soon as you can so that we may give the time to another person who may be waiting for service.

The usual session charge will be applied for appointments not kept or appointments that are canceled less than 24 hours in advance. Clients who need to cancel a Monday appointment may leave a message with the answering service 24 hours in advance to avoid charges.

4. **Collaborative Effort and Follow Through:** As a client you have the responsibility to complete those activities that you agree to do and to notify your Therapist or Case Manager when you are unable to do so. The Center staff works hard with you. If you have agreed to make phone calls or check up on something, please complete your task. If you are unable to do so, please let your Therapist or Case Manager know as soon as possible so they may help you. As a client you have the responsibility to accept the consequences of the outcome or no outcome if you do not do your part.
5. **Obtaining Services on Your Own:** As a client you have the responsibility to notify your care manager or Therapist of services that you obtained by yourself. So we will not spend time working on a service you already have, please let your Therapist or Case Manager know as soon as possible.
6. **Needs:** As a client you have the responsibility to communicate your needs to and ask questions of your Case Manager or Therapist as quickly as possible, understanding that your Case Manager or Therapist may not be able to satisfy "last minute" requests. Many agencies close at 5:00 pm. While you can reach the Center by phone after that time, we may not be able to get in touch with another agency to help you. It is also important to keep your requests reasonable. It is not always possible to fulfill requests, particularly housing. For example, there are no sources of free apartments.
7. **Conduct:** As a client you have the responsibility to conduct yourself appropriately when interacting with staff and other clients. Inappropriate behavior includes intoxication, threats, harassment, sexual advances or comments, and physical and verbal abuse. Weapons are not allowed in any the Center buildings. If discovered, they may be turned over to law enforcement. Smoking is not permitted in the Center's buildings. As a client you have the responsibility to give truthful information to your Therapist or Case Manager. Anyone who knowingly gives false information to their Therapist or Case Manager may lose the right to receive grant funded services at the Center. As a client you have the responsibility to keep the Center free of political candidate campaigning. No campaign materials (T-shirts, literature, cards, buttons, etc.) or speeches advertising a candidate for an active election are allowed in any the Center facility.
8. **Documentation:** As a client you have the responsibility to provide documentation needed to qualify you for services before services can be provided, such as, proof of where you live, current proof of income, and proof of HIV status if applicable. In order to provide you with grant funded services, your Therapist or Case Manager must show proof that you qualify.
9. **Fees:** As a client you have the responsibility to pay the fees you have agreed to and to notify your therapist if your insurance plan, or insurance company or income has changed. You will be responsible for paying any increase, if applicable, of co-insurance or copays incurred due to a delay in informing us of the insurance change. The Center has a sliding scale and tries to work with you in setting a reasonable fee. Once you agree to a fee, we count on that.

_____ _____/_____/_____
Client's Signature Date

_____ _____/_____/_____
Parent, Guardian or Authorized Representative's Signature Date

3.1.3.2.1 CONSENT FOR SERVICES FORM SLIDING SCALE/GRANT

I have read the statement of client rights and responsibilities and have answered all questions to the best of my ability. I am requesting services from the Montrose Center. I understand the Montrose Center strives to make mental health care affordable and accessible and will explore insurance and grant options if I am willing to provide the necessary eligibility paperwork including ID, insurance card, proof of income, proof of residence and proof of HIV status (if applicable). I further understand that if I do not provide proof of income, I will not be screened for a grant subsidy.

Optional Telehealth:

____ initial I understand that my therapist/psychiatrist/case manager (provider) may offer a telehealth session for therapy, case management or medication management using a HIPAA compliant telehealth platform as long as my insurance (or applicable grant funding) allows. My provider has explained to me how the video conferencing technology will be used and that I will not be in the same room as my provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation. I understand that if a staff member other than my provider is present during the session, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and I will have the right to request the following: 1) omit specific details of my psychosocial and medical history that are personally sensitive to me; (2) ask the other person to leave the telehealth room: and/or (3) terminate the session at any time. I have had the alternatives to telehealth explained to me, and I am choosing to participate in telehealth. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify: 1) That I have read or had this form read and/or had this form explained to me, 2) That I fully understand its contents including the risks and benefits of the session(s), 3) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction, and 4) I consent to services provided by telehealth.

____ initial **I am interested in paying a sliding fee based on my income below 725%[6] of the Federal Poverty Level and/or being assessed for grant subsidies for which I may be eligible.** [6]$93,380 for a household of 1- FY21

Please initial all statements below

____ initial I give the Montrose Center permission to verify if I am enrolled under Medicaid and if so, precertify my sessions.

____ initial I recognize grants are payers of last resort and that I must provide my Medicare, Medicaid and third party insurance information to be billed first.

____ initial The Montrose Center's fee for intake is $150.00. However, if I am providing an insurance card, proof of income less than 725% of the poverty level or eligible for a grant subsidy ***then I understand my portion of the intake fee is the insurance copay and/or allowable or the sliding scale for intake assessment, whichever is lower***. Certain grant subsidies may cover the cost of intake in its entirety.

____ initial If I provide an insurance card and proof of income less than 725% of the poverty level or request a grant subsidy then I understand my portion of the individual, family, group or IOP fee is the insurance copay or my sliding fee based on my household income, whichever is lower.

____ initial **I understand that the full fee (before sliding scale, grant subsidies or insurance company contracted rates are assessed) is:** individual session - $120.00; couple/family session - $60.00 per person, maximum - $120.00; group - $50.00; and Intensive Outpatient (IOP) Substance Abuse

Treatment - $200/day. The fee contracted by my insurance company may be discounted from these rates which will be explained in the Explanation of Benefits (EOB) I receive from my insurance company.

_____ initial If my insurance is out of network, I understand I will be required to pay the full fee and Montrose Center will submit claims to my insurance carrier as a courtesy to me. I am responsible for understanding my out-of-network coverage **and how my insurance will reimburse me**.

If I do not want the Center to bill my insurance:

_____ initial I have insurance but am requesting that the Center not bill it. I understand that I will be charged the full fee of $120 for individual sessions, $60.00 for my part of a family session, and $70.00 for my part of a group session.

Reason(s) I do not want to use my insurance (optional): _____

_____

_____ initial If I use insurance benefits, I understand I may have a deductible to meet before I am eligible to pay my copay and will be charged the full allowable rate (or my sliding fee if I am providing proof of income below 725% poverty) for services until the Explanation of Benefits is received informing our Benefits Specialist deductible have been met.

_____ initial I understand fees can be paid by cash, check, MasterCard/VISA. They cannot be paid with Discover, AMEX or any other credit card unless done through the Center's website and Paypal https://www.montrosecenter.org/forms/payment-form/. Fees may be subsidized by grant funds if eligibility criteria are met. I understand that payment is due at the time services are rendered.

_____ initial I understand a $25.00 fee will be assessed on each returned check and VISA/MasterCard charge.

Please initial all of the next 7 items

_____ initial I will update my insurance information prior to receiving any additional services after a change and recognize failure to do so may result in lapse in coverage during which I am solely responsible for the full cost of any services provided.

_____ initial **Unless I have Medicaid, I agree to pay the sliding scale rate for an individual or family session not cancelled at least 24 hours ahead of time. This may be higher than the rate contracted by my insurance company since no shows are not allowed to be billed to insurance.**

Please initial 1 of the next 2 items

_____ initial If there is a credit card on file, I agree that the Center may automatically charge the full rate for no showed appointments regardless of circumstance.

_____ initial If there is not a credit card on file, I will remit payment for my no show appointment prior to any additional service being provided - I may do so over the phone with a credit card or pay in person with cash, credit card or check.

_____ initial Before beginning services, I will talk with an eligibility staff person, review my fees for service and provided the necessary eligibility documents to determine my sliding fees based on my household income less than 725% poverty. (Fees to be completed by eligibility staff at time of consultation with client)

Intake ____, Individual ____, Family (per person) ____, Group ____,

IOP Substance use disorder treatment group ____, Crisis Intervention _____.

_____ initial I understand if my income, grant eligibility or insurance changes my fees may change too.

_____ initial I have had the fees specified above explained to me and I agree to accept services at this fee.

_____ initial I authorize the release of any medical or other information necessary to process any grant, insurance, Medicaid or Medicare claims. I assign payment of insurance and government benefits (Medicaid or Medicare) to be paid to the Montrose Center for behavioral health services provided by the Montrose Center staff.

_____ initial I understand that the Montrose Center was founded to serve the Lesbian, Gay, Bisexual, and Transgender community.

In the interest of providing quality care, the Montrose Center uses a team approach in treatment/case management including consultation among staff members, departments and volunteers. Please be aware that this can include reports of substance use. If you are aware of a conflict of interest based on a prior or current relationship with any Montrose Center staff member or volunteer, please report it to your intake or individual Therapist. Conflicts will be resolved on a case-by-case basis with the primary goal of the resolution being the best interest of you and the therapeutic relationship. Options for resolution include setting boundaries, reassignment to a different Therapist or Case Manager, or referral to another agency or private practitioner. I understand that there are limits to confidentiality and that they are outlined in the Client Handbook.

I certify that all of the information provided above is correct. I understand and have received an explanation of and copy of the Client Handbook containing the program rules, description of services, treatment process, regulations, client rights, HIPAA Privacy Act Notice, CM1500 claim form disclosure and grievance procedures, HIV, Hepatitis, sexually transmitted diseases, tobacco and TB education. After being fully informed of all of the above, I voluntarily consent to receive treatment and/or case management services from the Center. I further agree to give the Center staff permission to verify my Medicaid/Medicare enrollment monthly. I further agree that if I bring someone into my counseling or case management session that I am consenting to them having information that is discussed in that session. I understand that this consent does not extend outside of the session unless I have signed an additional specific release allowing them to do so.

X_____ ____/____/____ _____

Client's Signature Date Parent, Guardian, or Authorized Representative's Signature [7]

[7] Therapist/Case Manager, obtain proof of guardianship for the client record