PELICAN BAYOU COUNSELING AGENCY

Recipient Name: _____ **SSN**: _____
Medicaid #: _____

Client Contact Information:
Address: _____City: _____Zip: _____
Home Phone: _____ Cell: _____ Other Phone: _____

Parent/Guardian/Representative:
Name: _____ Relationship: _____
Address: _____City: _____Zip: _____
Home Phone: _____ Cell: _____ Other Phone: _____

Emergency Contact: (Release Must Be Completed)
Name: _____ Relationship: _____
Address: _____City: _____Zip: _____
Home Phone: _____ Cell: _____ Other Phone: _____
Email: _____

Primary Care Physician: _____
Address and Phone: _____

- Medical Conditions or Allergies: Yes☐ No ☐
- Use of medications or tools/equipment used to assist with daily living? Yes☐ No☐
- Any special needs we need to be aware of as we begin to provide services? Yes☐ No☐
  If you answered yes to any of the above questions, describe on back

Who referred you to our Agency: _____

Date of Birth: _____ **Age at Admit**: _____ **Sex**: M☐ F☐
Race: 1-White 2-Black/African American 3-Asian/Pacific 4-Amer Indian 5-Alaskan 6-Other
Ethnicity: 1-NonHispanic 2-Hispanic **Primary Language:** _____
Education: Last grade completed: ____ **Current School**: _____
Marital Status: 1-Never Married 2-Married 3-Widowed 4-Separted 5-Divorced
Household Comp: 1-Adult Only 2-Adult with relative 3-Adult with non-relative
4-Child with both parents 5-Child with one parent 6-Child with relative 7-Child with foster family
Veteran: 1-Yes 2-No **Natural Support** _____

_____ _____
Recipient's Signature Date

_____ _____
Parent/Guardian's Signature (If Applicable) Date

_____ _____
Staff Witness Signature Date

PELICAN BAYOU COUNSELING AGENCY

Client Emergency Information Form

Personal Information	
Client ID	
First name	
Middle name	
Last name	
Nickname	
Gender	
Citizenship	
Home address: Street	
City	
County	
Home phone	
Cellular phone	
Date of Birth (MM/DD/YYYY)	
Government ID or SSN	
Passport number	
Driver's license/state ID number	
Medical Information	
Physician's name and phone number	
Hospital preference	
Hospital phone number	
Blood type	
Medical conditions	
Allergies	
Current medications	
Emergency Information	
Emergency contact's name	
Relationship	
Address	
Phone number(s)	

PELICAN BAYOU COUNSELING AGENCY

Consent for Treatment – Child /Adolescent

1. **I, as legal guardian, consent for treatment as deemed necessary for the well-being of my child. I understand that my child may refuse treatment at any time unless court ordered. I, as legal guardian, understand that if treatment is refused it will be detrimental to the client and continued refusal may result in termination from the program.**

2. **I, as legal guardian, authorize Pelican Bayou Counseling Agency Inc. staff to seek emergency medical treatment in the event that my child becomes ill or has an accident while participating in services. This shall include emergency first aid by authorized personnel of the agency. I further understand that I will assume financial responsibility for any necessary medical care, including payment of physician, emergency room, rescue unit charge and other supplies (i.e. glasses).**

3. **I, as legal guardian, understand that certain information from my record may be contained in a computerized record system for reimbursement and statistical and program planning purposes.**

4. **A child's record relating to substance abuse is protected by Federal confidentiality rules (42 CRF Part 2). The Federal Rules prohibit this agency or its staff from making disclosure regarding substance abuse and/or treatment without the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information IS NOT sufficient for this purpose.**

5. **I, as the client, have received a copy of the client rights and responsibilities, a copy of the grievance procedure, and an orientation handbook. I understand the contents of the orientation handbook including the alleged benefits, potential risks and possible alternate methods of treatment for the service(s) being provided to me.**

6. **I, as legal guardian, hereby give consent for this client to be transported by Pelican Bayou Counseling Agency Inc. staff. I agree that upon my child's riding in any vehicle provided by PBCA, I hereby release and discharge PBCA from all claims, demands, damages, actions and from any and all liability of any nature whatsoever for any injury, harm or complication that may result directly or indirectly by reason of any transportation of daily services provided by an individual under the direction of PBCA.**

7. **I, as legal guardian, have read and understand the Confidentiality Regulations as developed by PBCA. I also understand that PBCA staff will/have explain(ed) the consequences of refusing treatment.**

8. **I, as legal guardian, understand that the Behavioral Health Rehabilitation Services Program does not utilize physical restraints. Employees are trained in verbal de-escalation techniques and will attempt to resolve crises in the least restrictive manner possible. However, in the case of crisis/emergency situations staff will call 911 and assist in ensuring environmental safety.**

Signed:_____ **Date:**_____
Recipient

Signed: _____ **Date:**_____
Legal Guardian

Signed:_____ **Date:**_____
PBCA

PELICAN BAYOU COUNSELING AGENCY

9403 Mansfield Road, Shreveport, La 71118
Telephone (318) 861-8938 ● Facsimile (318) 862-3554
1st NE Springhill, Louisiana 71075
Telephone (318) 382-9700 ● Facsimile (318) 382-9703

Recipient Grievance (Complaint) Policy

I. Policy

a. Recipient and/or Parent/Guardian have the right to complain if they believe they have been treated wrongly. They will not be subject to disciplinary actions or reprisal in any form as a result of complaining.

II. Procedure

a. First you should set up a meeting with the staff member that provides your services.
b. If the two of you are unable to resolve the problem, you should request a meeting with their supervisor. The supervisor will meet with you in three (3) business days.
c. If your problem is not resolved, you have five (5) days to file a formal complaint.
d. To file a formal complaint, you must submit your complaint in writing and turn it into the Office Manager. If you need assistance with your written complaint, staff is here to help you.
e. The Clinical Director will meet with you and try to resolve your problem. We will issue a written response to you within (5) days, excluding weekends and holidays.
f. If the issue has not been resolved, a meeting will be scheduled with the Executive Director. Thereafter, a formal written response will be issued to you within five (5) days, excluding weekends and holidays.
g. If you remain unsatisfied with the findings of the written response, you may contact or file a complaint with:
   Office of Behavioral Health, Regional Director - Wendy Goad (318) 676- 5111
   Mental Health Advocacy Center – Attorney Joseph Seyler (318) 676-7332
   Or other appropriate agencies such as professional licensing boards and/or legal aid that may serve as your advocate.

_____ _____
Recipient's Signature Date

_____ _____
Parent/Guardian's Signature (If Applicable) Date

_____ _____
Staff Witness Signature Date

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EMERGENCY/ CRISIS PROCEDURE

If my child has a crisis, Pelican Bayou Counseling Agency Inc. is to be notified immediately. I must first attempt to call the office as follows:

(318) 861-8938 – Shreveport
(318) 382-9700 – Minden

If a staff member does not answer, I will leave a message with the answering service when they answer. At which time the answering service will take my message and contact a Clinical Manager. I understand that a Clinical Manager will contact me promptly.

I will call 911 if there is immediate danger.

I fully understand the emergency crisis procedure and what is expected of me should an emergency/crisis arise. My signature below indicates I have received a copy of this procedure.

Signed:_____ **Date:**_____
Recipient

Signed:_____ **Date:**_____
Legal Guardian

Signed:_____ **Date:**_____
Staff

PELICAN BAYOU COUNSELING AGENCY

TELEHEALTH CONSENT FORM

I, _____, hereby consent to engage in telehealth services with _____ (Licensed Professional Counselor, Psychiatrist, or Therapist). I understand that this consent applies to any provider I may see for telehealth services, and once completed, this form will serve as consent for all future sessions, regardless of the specific provider. I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a client's care.

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

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person sessions.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am
5. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's

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

_____ _____

Patient's Signature Date

_____

Therapist Signature

Therapist reviewed Telehealth Consent Form with client, client understands and agrees to the above advisements, and client has consented to receiving sessions from staff via Telehealth

PELICAN BAYOU COUNSELING AGENCY

Member's Freedom of Choice

I am aware that providers and facilities available to me can be found within the Members Tab and Provider Search on my designated plans website.

Pelican Bayou Counseling Agency
9403 Mansfield Road, Shreveport, La 71118
Telephone (318) 861-8938 ● Facsimile (318) 862-3554115
1st NE Springhill, Louisiana 71075
Telephone (318) 382-9700 ● Facsimile (318) 382-9703

The provider I choose is: (Enter provider name and phone number in box)
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's signature in box)

Member Name:	Member Date of Birth:

Member/Legal Guardian Signature:	Legal Guardian Name:

Today's Date:

Instructions for Provider:
A Freedom of Choice Form is required prior to service authorizations. The form requires a Member's signature, date, an identified provider and provider telephone number. This Provider assumes responsibility of coordinating care with the prior provider of record.

Provider Representative Signature:

PELICAN BAYOU COUNSELING AGENCY

ORIENTATION CHECKLIST AND RECIEPT OF RECIPIENT HANDBOOK

The following information has been provided as part of the consumer orientation. A check of the item indicates that it has been fully explained and is understood by the consumer.

- ✔ Agency Mission
- ✔ Rights and grievance and appeal procedures
- ✔ Services provided, days and hours of operation, expected level of participation
- ✔ Access to emergency services, after hours
- ✔ Code of ethics/conduct
- ✔ Confidentiality policy, limits of confidentiality
- ✔ Methods, opportunities, and policy on input
- ✔ Explanation of financial obligations, fees, and financial arrangements
- ✔ Notification and purpose of participation in the outcome management process
- ✔ Fire, safety, and emergency precautions
- ✔ Policy on restraint (and seclusion, if applicable)
- ✔ Policy on tobacco products
- ✔ Policy on illicit or licit drugs brought into the program
- ✔ Identification of the person responsible for service coordination
- ✔ Program rules, including restrictions and the loss and regaining of rights and
- ✔ Advanced directives information, if appropriate
- ✔ Purpose and process of assessment
- ✔ Individual plan development and expectations of family involvement
- ✔ Discharge/transition criteria and procedures
- ✔ Education designed to reduce identified physical risks
- ✔ Training regarding infections and communicable diseases
- ✔ Instruction and training on equipment features, set up, use, and troubleshooting
- ✔ Education regarding advance directives
- ✔ Training and education regarding medications
- ✔ Education on drug screening practices
- ✔ Education and training program that addresses all areas identified in the standard
- ✔ Education that includes wellness
- ✔ Education that includes resilience and recovery
- ✔ Education that includes the interaction between mental and physical health
- ✔ Education that includes self-management of identified medical conditions and behavioral health concerns
- ✔ Education on wellness and recovery
- ✔ Training and education on the areas listed in the standard, based on the needs of each person served
- ✔ Informing and education of employees of the host or contracting organization
- ✔ Opportunities to enhance advocacy skills through training
- ✔ Prescription medication brought into the program
- ✔ Expectations for legally required appointments, sanction, or court notifications
- ✔ Curriculum-based program component for each person served that meets all requirements listed in the standard
- ✔ Educational program the address development of community living skills, social skills and supports, and vocational skills
- ✔ Education and training program that is developmentally and age appropriate and includes all elements listed in the standard

By signing this statement, I validate that I have received a copy of the Pelican Bayou Counseling Agency (PBCA) recipient handbook. I further agree that a representative of PBCA has explained all aspects of this manual to me.

Recipient's Signature_____ Date: _____

Parent/Guardian's Signature (If Applicable): _____ Date: _____

Checklist/Orientation completed by: _____ Date: _____

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Telephone (318) 382-9700 ● Facsimile (318) 382-9703

Authorization to Release or Obtain Health Information
(including paper, oral, and electronic information)

Recipient's Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

Pelican Bayou Counseling Agency Inc.
Mental Health Rehabilitation Agency

☐ RELEASE information TO or ☐ OBTAIN information FROM
(Place an "X" in the box that indicated if the information is being released OR requested)

Name: _____

Mailing Address: _____

City/State/Zip Code: _____

Relationship: **PRIMARY CARE PHYSICIAN** Telephone:

The Purpose of this Authorization is to gather information needed to obtain and provide Mental Health Rehabilitation services.

In compliance with state and federal laws which require special permission to release otherwise privileged information, please release the following records: *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

X Discharge summary X Psychiatric/ Psychological Evaluations X Medical History, Examination, Reports
X Psychotherapy Needs X Prescriptions X Alcoholism
X Drug Abuse X HIV (AIDS) X Sexually Transmitted diseases
X Genetics X Vocational Rehabilitation X Laboratory Reports and X-Ray Reports
X School Records (Including: Attendance, progress reports, grades, IEP, and behavioral problems/plan)
Other:_____

This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

_____ _____
Signature of Individual or person Representative authorized by law Date

For PBCA Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal representative has been obtained.

_____ _____
Signature of Individual or person Representative authorized by law Date

You have the right to revoke this authorization at any time. To revoke, send a written statement to: Pelican Bayou Counseling Agency Inc. Attn: Records Office 9403 Mansfield Road Shreveport, La 7118. Your request will become valid when the Records Office receives it.

PELICAN BAYOU COUNSELING AGENCY

9403 Mansfield Road, Shreveport, La 71118
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1st NE Springhill, Louisiana 71075
Telephone (318) 382-9700 ● Facsimile (318) 382-9703

Authorization to Release or Obtain Health Information (including paper, oral, and electronic information)	
Recipient's Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

Pelican Bayou Counseling Agency Inc.
Mental Health Rehabilitation Agency

☐ RELEASE information TO or ☐ OBTAIN information FROM
(Place an "X" in the box that indicated if the information is being released OR requested)

Name: _____

Mailing Address: _____

City/State/Zip Code: _____

Emergency Contact: (Relationship) Telephone:

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☐ Discharge summary ☐ Psychiatric/ Psychological Evaluations ☐ Medical History, Examination, Reports
☐ Psychotherapy Needs ☐ Prescriptions ☐ Alcoholism
☐ Drug Abuse ☐ HIV (AIDS) ☐ Sexually Transmitted diseases
☐ Genetics ☐ Vocational Rehabilitation ☐ Laboratory Reports and X-Ray Reports
☐ School Records (Including: Attendance, progress reports, grades, IEP, and behavioral problems/plan)
☐ Other:_____

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_____ _____
Signature of Individual or person Representative authorized by law Date

For PBCA Use When Requesting Records

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_____ _____
Signature of Individual or person Representative authorized by law Date

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1st NE Springhill, Louisiana 71075
Telephone (318) 382-9700 ● Facsimile (318) 382-9703

Authorization to Release or Obtain Health Information
(including paper, oral, and electronic information)

Recipient's Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

Pelican Bayou Counseling Agency Inc.
Mental Health Rehabilitation Agency

☐ RELEASE information TO or ☐ OBTAIN information FROM
(Place an "X" in the box that indicated if the information is being released OR requested)
Name: Bayou Health Plans

Mailing Address: P.O. Box 629

City/State/Zip Code: Baton Rouge, La 70821-0629

Relationship: **Health Care Provider** Telephone: 1-855-229-6848

The Purpose of this Authorization is to gather information needed to obtain and provide Mental Health Rehabilitation services.

In compliance with state and federal laws which require special permission to release otherwise privileged information, please release the following records: *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

X Discharge summary X Psychiatric/ Psychological Evaluations X Medical History, Examination, Reports
X Psychotherapy Needs X Prescriptions X Alcoholism
X Drug Abuse X HIV (AIDS) X Sexually Transmitted diseases
X Genetics X Vocational Rehabilitation X Laboratory Reports and X-Ray Reports
X School Records (Including: Attendance, progress reports, grades, IEP, and behavioral problems/plan)
X Other:_____

This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

_____ _____
Signature of Individual or person Representative authorized by law Date

For PBCA Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal representative has been obtained.

_____ _____
Signature of Individual or person Representative authorized by law Date

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PELICAN BAYOU COUNSELING AGENCY

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1st NE Springhill, Louisiana 71075
Telephone (318) 382-9700 ● Facsimile (318) 382-9703

Authorization to Release or Obtain Health Information (including paper, oral, and electronic information)	
Recipient's Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

Pelican Bayou Counseling Agency Inc.
Mental Health Rehabilitation Agency

☐ RELEASE information TO or ☐ OBTAIN information FROM
(Place an "X" in the box that indicated if the information is being released OR requested)

Name: _____

Mailing Address: _____

City/State/Zip Code: _____

Relationship: **Psychiatrist** Telephone:

The Purpose of this Authorization is to gather information needed to obtain and provide Mental Health Rehabilitation services.

In compliance with state and federal laws which require special permission to release otherwise privileged information, please release the following records: *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

☐ Discharge summary ☐ Psychiatric/ Psychological Evaluations ☐ Medical History, Examination, Reports
☐ Psychotherapy Needs ☐ Prescriptions ☐ Alcoholism
☐ Drug Abuse ☐ HIV (AIDS) ☐ Sexually Transmitted diseases
☐ Genetics ☐ Vocational Rehabilitation ☐ Laboratory Reports and X-Ray Reports
☐ School Records (Including: Attendance, progress reports, grades, IEP, and behavioral problems/plan)
☐ Other:_____

This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

_____ _____
Signature of Individual or person Representative authorized by law Date

For PBCA Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal representative has been obtained.

_____ _____
Signature of Individual or person Representative authorized by law Date

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Authorization to Release or Obtain Health Information (including paper, oral, and electronic information)	
Recipient's Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

Pelican Bayou Counseling Agency Inc.
Mental Health Rehabilitation Agency

☐ RELEASE information TO or ☐ OBTAIN information FROM
(Place an "X" in the box that indicated if the information is being released OR requested)

Name: _____

Mailing Address: _____

City/State/Zip Code: _____

Relationship: **School** Telephone:

The Purpose of this Authorization is to gather information needed to obtain and provide Mental Health Rehabilitation services.

In compliance with state and federal laws which require special permission to release otherwise privileged information, please release the following records: *(Place an "X" in the box(es) that apply to the information you want released or you want obtain.)*

X Discharge summary *X* Psychiatric/ Psychological Evaluations *X* Medical History, Examination, Reports
X Psychotherapy Needs *X* Prescriptions *X* Alcoholism
X Drug Abuse *X*HIV (AIDS) *X* Sexually Transmitted diseases
X Genetics *X* Vocational Rehabilitation *X* Laboratory Reports and X-Ray Reports
X School Records (Including: Attendance, progress reports, grades, IEP, and behavioral problems/plan)
X Other:_____

This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

_____ _____
Signature of Individual or person Representative authorized by law Date

For PBCA Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal representative has been obtained.

_____ _____
Signature of Individual or person Representative authorized by law Date

You have the right to revoke this authorization at any time. To revoke, send a written statement to: Pelican Bayou Counseling Agency Inc. Attn: Records Office 9403 Mansfield Road Shreveport, La 7118. Your request will become valid when the Records Office receives it.

PELICAN BAYOU COUNSELING AGENCY

Member Name (First, Last Name): _____ Member DOB: _____
Member ID #: _____

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from one provider unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. AmeriHealth Caritas Louisiana: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588
3. Healthy Blue: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. Louisiana Healthcare Connections: https://providersearch.louisianahealthconnect.com/ or call 1-866-595- 8133 (Hearing Loss: 711)
5. United Healthcare Community: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514
6. Humana Healthy Horizons, you can visit their website at humana.com/medicaid/louisiana or call their Member Services at 1-800-448-3810 (TTY: 711)

The provider that I have freely selected to deliver MHR services to me, or my child is:

Provider Name:	Pelican Bayou Counseling Agency
Provider Phone Number:	Shreveport 318-861-8938 Minden (318) 382-9700
Provider Contact Name:	Pelican Bayou Counseling Agency
Provider Address:	9403 Mansfield Rd. Shreveport, LA 71118 1st NE Springhill, Louisiana 71075

By signing the form below, I understand that I have chosen to receive services from this MHR provider, and I acknowledge that it is my responsibility to notify my previous provider, so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

_____ _____
Member/Legal Guardian Signature Date

_____ _____
Printed Legal Guardian Name Date

Providers Information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

_____ _____
Provider Signature Date