Cultivate
BEHAVIORAL HEALTH & EDUCATION

**DOCUMENTS TO COMPLETE AT INTAKE**

- ☐ Intake Packet – do before starting therapy interview
  - ☐ Informed Consent for Telehealth Services (if applicable)
  - ☐ Electronic Signature Consent Form (if you are having the client sign forms electronically or ever plan to have them do so)
  - ☐ Client Demographics and Emergency Contact
  - ☐ Therapy Services Acknowledgements and Consents
  - ☐ Targeted Case Management Service Participation Agreement (if they are interested in this service and are age 21 or under)
  - ☐ Consent for the Use and Disclosure of Protected Health Information (PHI)
  - ☐ Consent for the Release of Confidential Information
  - ☐ Parent/School Consent (for minor students)
  - ☐ Authorization for the Release and Exchange of Information (for PCP)
  - ☐ Therapy Services Program Guide (client keeps)
  - ☐ Notice of Privacy Practices (client keeps)
- ☐ Comprehensive Assessment (use the electronic form in Oasis)
- ☐ Initial Treatment Plan (use electronic form in Oasis)
- ☐ Treatment Plan Signature Page (use either paper or electronic)
- ☐ Intake Progress Note (if 1 hour, code 90791; if over an hour, code "Associate/Licensed Intake Longer Than an Hour" and 99354)

• 334 Beechwood Rd Suite 502 Fort Mitchell KY, 41017
• PHONE: 859.360.3006
• FAX: 859.360.3053

Senate Bill 150

The client's legal name is _____.

The client's chosen first name is the same as above or _____.

The client identifies as [circle] male, female, non-binary, fluid or other _____.

The client's pronouns are [circle] she/her, he/him, they/them, or other _____.

*Gender affirming care, as defined by the World Health Organization, includes a wide range of social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth.*

I consent for my child to receive gender affirming care if needed. Yes / No [circle]

_____
Guardian Signature & Date

_____
CBHE Signature & Date

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**INFORMED CONSENT FOR THERAPY TELEHEALTH SERVICES**

Client Name: _____ Date: _____

**Definition of Telehealth**

Telehealth involves the use of electronic communications to enable Cultivate Behavioral Health & Education's mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CBHE utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that my sessions are not recorded unless I give written permission for recording. Further, I understand that I am not to record sessions.
5. I understand that if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.
6. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my therapist, I may be directed to "face-to-face" psychotherapy.
7. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation

other than my therapist in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

9. I understand that my express consent is required to forward my personally identifiable information to a third party.
10. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state of Kentucky.
11. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

**Payment for Telehealth Services**

Cultivate Behavioral Health & Education will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. If insurance does not cover telehealth or if there is no insurance coverage, the individual may pay out-of-pocket for services.

**Patient Consent to the Use of Telehealth**

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

| Client Signature | Date | Parent/Guardian Signature | Date |
|---|---|---|---|
| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |

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# ELECTRONIC SIGNATURE CONSENT FORM

For the purposes of this Consent, “Client”, “You” and “Your” refers to You, the person accessing the forms for Cultivate Behavioral Health & Education. “Agency”, “Ourselves”, “We” and “Us” refers to Cultivate Behavioral Health & Education. “Party”, “Parties”, or “Us”, refers to both the Client and Agency, or either the Client or Agency.

The purpose of this consent is to ensure that you are fully aware of the significance of agreeing to receive and sign documents electronically.

**Terms**

“Electronic documents” include documents you may complete via our electronic health record system. They can typically be printed out but exist independently in an electronic form on a server.

An “electronic signature” includes any mark, symbol, sound or process that is written, stamped, engraved, attached to or logically associated with an electronic document and executed by a person with the intent to sign. Just like you can legally “sign” a printed document by making your mark, whether that be your signature in ink or an “X,” so too you can "sign" an electronic document by making your mark, whether that be a high-tech encrypted or digital signature. These are all “electronic signatures.”

**1. Right to Receive Paper Documents:** You have the right to have any document provided in paper or non-electronic form. If you want a paper copy of any document, you may contact the administrative assistant for the organization. Your request will be reviewed and approved/denied by the program supervisor.

**2. Right to Withdraw Consent.** You have the right to withdraw your consent to sign electronic documents with electronic signature by contacting Cultivate Behavioral Health & Education through the Contact Us link on our websites or by calling your local Cultivate Behavioral Health & Education office. The legal validity and enforceability of the electronic documents, signatures and deliveries used prior to withdrawal of consent will not be affected. In other words, all prior electronic signatures shall be fully valid and enforceable.

**3. Consent to Electronic Signatures and Documents:** By completing this consent form, you are providing electronic consent to the use of electronic documents and signatures.

**CONSENT**

I understand that the Agency employs a proprietary digital signature technology developed by the electronic health record software developer. This technology combines your unique user identity within the software and current date stamp to ensure you are the owner of the signature. By signing this form, I consent and agree to use this digital signature method. I understand that if I do not wish to “sign” this way, I may request to have the documents printed out for me, sign by hand, and give to the agency employee conducting my interview.

| Client Signature | Date | Parent/Guardian Signature | Date |
|---|---|---|---|

| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |
|---|---|---|---|

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# CLIENT DEMOGRAPHICS & EMERGENCY CONTACT INFO

## Client Demographics

*Client Name: _____

*Parent/Guardian Name: (if minor) _____

*Relationship to Client: _____ *Phone: _____

Parent/Guardian Name: (if minor) _____

Relationship to Client: _____ Phone: _____

*Client Marital Status: _____

*Client Primary Language: _____

*Client Ethnicity _____

## Emergency Contact Information

*Emergency Contact Name: _____

*Relationship to Client: _____ *Phone: _____

## Emergency Contact Information

Emergency Contact Name: _____

Relationship to Client: _____ Phone: _____

*Required information. Per regulations, those fields marked with * must be completed.*

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# THERAPY SERVICES ACKNOWLEDGMENT & CONSENTS

*Please INITIAL next to each item for acknowledgement/consent.*

Client name _____ Today's Date _____

## Service Participation Agreement

_____ I acknowledge the need for the service in order to maintain myself or my child in the least restrictive environment.

_____ I acknowledge that I have been given the Program Guide and informed of the services provided in association with, including the guidelines and expectations of the program including information about the confidentiality of Cultivate Behavioral Health & Education's therapy services and targeted case management, client rights, the grievance policy, my responsibilities, availability of staff, and treatment approaches.

_____ I also understand that it is my responsibility to keep my insurance or my child's insurance up to date and disclose all insurance information including changes.

_____ I consent to treatment for my myself or my child and/or family at Cultivate Behavioral Health & Education. Treatment will consist of weekly counseling for mental health issues based on the assessment information for the treatment plan that myself or my child and family develop with the therapist and/or case manager. Treatment may include targeted case management services, and/or group counseling. I realize that I may withdraw this consent and discontinue treatment at any time.

_____ I understand that if I no longer meet or my child no longer meets the eligibility requirements of this program, my case or my child's case may be terminated.

_____ I also understand that this service is voluntary, and I may choose to discontinue services. Or, as the legal guardian, I may choose to discontinue services for my child at any time.

## Acknowledgement of Client Rights

_____ As a client of Cultivate Behavioral Health & Education, I have the right to:

- Be treated with respect, dignity and care;
- Have services that help and benefit me or my family;
- Receive respect for my culture and ethnic identity, gender, age, sexual preference, marital status, religion, and disability;
- Have information about me and my family maintained in a confidential manner;
- Actively participate in making a service plan, goals and objectives to suit my needs, which includes my agreement to work towards clear outcomes (as applicable);
- Services given by providers who are competent and focused on my individual care;
- As a legal guardian of a minor the right to specific information regarding my child's services; and
- Make a complaint or file a written grievance to my Cultivate Behavioral Health & Education's employee.

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## Acknowledgement of Confidentiality

_____ I understand that Cultivate Behavioral Health & Education may use or disclose information for treatment and/or services, to obtain payment for treatment/services provided, and as necessary for the operations of Cultivate Behavioral Health & Education as outlined in the "Notice of Privacy Practices". In the case of suspected neglect, abuse, or abandonment, I understand that Cultivate Behavioral Health & Education will report this to the appropriate authorities, as required by law.

_____ I understand that information regarding services received at Cultivate Behavioral Health & Education is confidential in nature and I should not disclose personal and/or confidential information. I also understand that if, at any time, I voluntarily speak to any media concerning services received by others or myself at Cultivate Behavioral Health & Education, I discharge Cultivate Behavioral Health & Education from liability in the event that I voluntarily or inadvertently disclose confidential information about others or myself.

## Grievance Procedure

_____ I and/or my legal guardian understand that in order to ensure individuals receiving services from CBHE have an opportunity to exercise rights, a grievance and appeals procedure is available to me if I wish to make a compliant, bring attention to any potential problems and/or appeal a decision made regarding my services with CBHE.

## Informed Consent

_____ I have been informed of the services available through Cultivate Behavioral Health & Education, and in association with Medicaid, including the guidelines and expectations of the identified program.

_____ I acknowledge I have been informed of service options and the modes of delivery.

## Transportation Consent

_____ Cultivate Behavioral Health & Education (CBHE) employees may provide transportation to clients and their families for a variety of activities and appointments. These activities are related to their work in both our treatment and community-based programs. In general, employees providing transportation use vehicles drawn from the agency vehicle pool. When no agency vehicle is available, employees may use their own vehicles for agency business. I authorize Cultivate Behavioral Health & Education and its employs to transport me and other family members to Cultivate Behavioral Health & Education programs in vehicles owned by Cultivate Behavioral Health & Education or its employee(s). I consent to the use of vehicles owned by employees of Cultivate Behavioral Health & Education in order to transport me and other family members. I consent to the above provisions and I expressly state that I have read, understood and am familiar with the above provisions and that I sign this consent form of my own free will.

## Freedom of Choice

_____ I understand that the choice of providers is my responsibility and right as my own guardian or as the guardian of my child. I further understand that I have the right to contact other providers so that I may determine the best provider for myself or my child. I also understand that I may at any time choose another provider for this service by notifying my current provider. I know that I have to right to review the Kentucky Medicaid website for a list of providers in my region at dbhdid.ky.gov/providerdirectory/providerdirectory.aspx. and have chosen Cultivate Behavioral Health & Education as my provider.

| Client Signature | Date | Parent/Guardian Signature | Date |
|---|---|---|---|
| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |

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# TARGETED CASE MANAGEMENT SERVICE PARTICIPATION AGREEMENT

I acknowledge the need for the service in order to maintain my child in the least restrictive environment.

I acknowledge that I have been informed of the services provided in association with, including the guidelines and expectations of the program including information about the confidentiality of Cultivate Behavioral Health & Education therapy services, client rights, the grievance policy, my responsibilities availability of staff, and treatment approaches.

I consent to treatment for my child and family at Cultivate Behavioral Health & Education. Treatment will consist of weekly counseling for mental health issues based on the assessment information for the treatment plan that my child and family develop with the therapist, case manager. Treatment may include targeted case management services, and/or group counseling. I realize that I may withdraw this consent and discontinue treatment at any time.

I understand that if my child no longer meets the eligibility requirements of this program, my child's case may be terminated.

I also understand that this service is voluntary and as the legal guardian, I may choose to discontinue services for my child at any time.

| Client Signature | Date | Parent/Guardian Signature | Date |
|---|---|---|---|
| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |

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# CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that as a condition to my receiving treatment and/or services from Cultivate Behavioral Health & Education, the agency may use or disclose my personally identified Protected Health Information (PHI) for treatment and/or services, to obtain payment for treatment/services provided, and as necessary for the operations of Cultivate Behavioral Health & Education. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to me, and which I have had the opportunity to review.

I also understand that I have the right to request Cultivate Behavioral Health & Education to restrict how my health information is used or disclosed. Cultivate Behavioral Health & Education does not have to agree to my request for the restriction, but if the agency does agree, it is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that Cultivate Behavioral Health & Education has acted in relation to my consent for use or disclosure of my protected health information. Provision of future treatment/services may be withdrawn if I revoke/withdraw my consent.

I understand that Cultivate Behavioral Health & Education reserves the right to change its Notice of Privacy Practices. I further understand that prior to implementation of any changes, Cultivate Behavioral Health & Education will post a revised Notice in the facility and provide a copy upon request.

_____

Name of Client Being Served by Cultivate Behavioral Health & Education

| Client Signature | Date | Parent/Guardian Signature | Date |
|---|---|---|---|
| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |


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# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____, parent/guardian of _____
*(Print Name of Parent, legal Guardian, or client of legal age)* *(Printed Name of Client — or indicate self)*

Client Date of Birth: _____, voluntarily authorize Cultivate Behavioral Health & Education to exchange

information with: _____
*(Name of Organization)*

I understand the purpose of this disclosure is to disclose and receive information and records as necessary to obtain history pertinent to future treatment needs, assist in coordinating appropriate and pertinent services, creating a comprehensive service plan, and provide ongoing collaboration, contact, continued care and/or referrals.

The following is requested for release to Cultivate Behavioral Health & Education:

| | | | |
|---|---|---|---|
| ☐ | Collaboration / contact | ☐ | Psychological, Psychiatric, Diagnostic Evaluations |
| ☐ | Admission / Discharge Summaries | ☐ | Psychological, Psychiatric, Diagnostic Assessments |
| ☐ | Treatment Plans | ☐ | School testing/evaluation results |
| ☐ | Progress Reports | ☐ | IEP / 504 / behavioral plans |
| ☐ | Immunization and Medication history | ☐ | Treatment information including HIV/AIDS |
| ☐ | Court records (legal charges, court orders) | ☐ | Attendance records |
| ☐ | Safety Plans | ☐ | Disciplinary records |
| ☐ | Placement history / log | ☐ | All records related to Drug / Alcohol (Drug Screening) |
| ☐ | Entire file | ☐ | Other: |

I understand that mine or my child's records are protected under Federal and State regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations, including laws regarding mandatory reporting of suspected abuse, neglect exploitation or assessment of serious harm to self or others. I understand that I may revoke this consent at any time, by notifying the agency in writing, and that the request for revocation will be signed, dated and witnessed so that it does not conflict with requests made previously for release. I also understand eligibility, enrollment, provision and/or payment of services, is not contingent on this release of information. I understand that I am entitled to a copy of this form and may request to view the information retained from it. I understand I am entitled to one free copy of my records. Cost for subsequent copies of records is .20 per page. Requests for records must be made in writing and submitted to the Program Director of engaged service(s).

This authorization will expire on ____/____/____, (maximum 12 months) or upon closure of services with Cultivate Behavioral Health & Education.

I further acknowledge that the consent was fully explained to me and this consent was given of my own free will.

Executed this _____ day of_____, 20_____

| | | | |
|---|---|---|---|
| Client Signature | Date | Parent/Guardian Signature | Date |
| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |

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# PARENT AND SCHOOL CONSENT

Client Name_____ Date _____

To Whom It May Concern:

Cultivate Behavioral Health & Education employees may provide behavioral health services to clients and their families for a variety of activities and appointments. These activities are related to their work in both our treatment and community-based programs. In general, employees will be providing counseling and collateral services with my child and school personnel.

I consent to Cultivate Behavioral Health & Education and its employee, _____, to provide services to my child(ren)

_____
_____

| | | | |
|---|---|---|---|
| Client Signature | Date | Parent/Guardian Signature | Date |
| Parent/Guardian Signature | Date | CBHE Representative/Title | Date |


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# AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

Dear _____,

This letter serves to provide the appropriate release of information for ongoing contact between Cultivate Behavioral Health & Education and your office regarding our mutual client: _____.

I, _____, give full authorization for _____ to furnish information regarding my physical and mental health information to Cultivate Behavioral Health & Education, for the purpose of collaboration and continuity of care from _____ to _____. This consent is subject to revocation by the undersigned and remains in force for 180 days after the closure of the case with Cultivate Behavioral Health & Education. By signing and dating this release of information, I allow the person listed below to share specific record information.

Client Name _____ Client DOB _____

Client Address_____

Client/Guardian Signature (If applicable) _____ Date_____

Please offer the following information at your earliest convenience. The entire medical record is not necessary, as the questions below meet Medicaid requirements.

1. Is the above-named client currently receiving treatment through your office? If yes, what are the current concerns and/or diagnoses?

_____
_____
_____

2. Current medications:

_____
_____
_____

3. Response to treatment:

_____
_____
_____

_____ _____

Physician Signature Date

Senate Bill 150

The client's legal name is _____.

The client's chosen first name is the same as above or _____.

The client identifies as [circle] male, female, non-binary, fluid or other _____.

The client's pronouns are [circle] she/her, he/him, they/them, or other _____.

*Gender affirming care, as defined by the World Health Organization, includes a wide range of social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth.*

I consent for my child to receive gender affirming care if needed. Yes / No [circle]

_____
Guardian Signature & Date

_____
CBHE Signature & Date