



Teri's Health Services – Consent for Treatment

14040 N. Cave Creek Rd. Suite 205 Phoenix, Az 85022
 115 S. Candy Lane Suite 115C2 Cottonwood, Az 86326
 ph: 602-348-7073 fax: 602-429-8602

Client Name:

Family History

Date of Birth:

Type of Illness	Family History of:
Heart disease	
Cancer breast	
Cancer colon	
Cancer lung	
Cancer ovaries	
Cancer prostate	
Cancer uterus	
Cancer/other:	
Stroke	
Depression	
Diabetes	
High blood pressure	
Thyroid disease	
Mental illness	
Substance use	
Other:	
Other:	
Other:	

Facility:

Email for Telemed-Link:

Address:

Phone Number:

Insurance Carrier:

Insurance #:

Insurance Group #:

Race:

Gender:

Pharmacy:

Pharmacy location:

Chronic Medical conditions:

Past surgeries:

Past Hospitalizations:

Do you have any concerns about your psychiatric health?

Do you have any concerned about your physical health?



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NOTICE OF PRIVACY PRACTICES

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

Effective Date: May 15, 2020

PURPOSE

Teri's Health Services is required by law to maintain the privacy of your health information in accordance with federal and state law. This Notice of Privacy Practices ("Notice") outlines our legal duties and privacy practices with respect to health information. We are required by law to provide you with a copy of this Notice and to notify you following a breach of your unsecured health information.

We will abide by the terms of the Notice. We reserve the right to make changes to this Notice as permitted by law. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Each version of the Notice will have an effective date listed on the first page. If we change this Notice, you can access the revised Notice on our website (terishealthservices.org) or from the receptionist at any Teri's Health Service location.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information without your written authorization.

Treatment. We may use and disclose your health information to provide you with medical treatment and services. For example, your health information may be disclosed to physicians, nurses, or other health care providers who are involved in your care to coordinate or manage your health care services or to facilitate consultations or referrals as part of your treatment. If you are in a group home or facility we will coordinate care with these entities and provide your information of treatment to the home staff and owners. We will provide your documentation for the facility or group home to have a copy and place in their state file, use for their licensing requirements of Arizona, and place in their own electronic health information system.

Payment. We may use and disclose your health information to obtain payment for the services we provide to you. For example, we may disclose your health information to seek payment from your insurance company or from another third party. We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment or in order to determine whether your insurance company will cover the cost of the treatment.

Health Care Operations. We may use and disclose your health information to conduct certain of our business activities, which are called health care operations. These uses and disclosures are necessary to run our business and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing, and collection services. In these cases, we will enter into a written agreement with the business associates to ensure they protect the privacy of your health information.



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Family Members and Friends for Care and Payment and Notification. If you verbally agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your health information. We may disclose certain health information to your family, friends, and anyone else whom you identify as involved in your health care or who helps pay for your care; the health information we disclose would be limited to the health information that is relevant to that person's involvement in your care or payment for your care. We may also make these disclosures after your death as authorized by Arizona law unless doing so is inconsistent with any prior expressed preference. We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your location, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

Required by Law. We may disclose your health information when required by law to do so.

Public Health Reporting. We may disclose your health information to public health agencies as authorized by law. For example, we may report certain communicable diseases to the state's public health department.

Reporting Victims of Abuse or Neglect. We may disclose health information to the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. We only make this disclosure if you agree or when we are required or authorized by law to make the disclosure.

Health Care Oversight. We may disclose your health information to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative, and criminal proceedings, as necessary for oversight of the health care system, government programs, and civil rights laws.

Legal Proceedings. We may disclose your health information in the course of certain administrative or judicial proceedings. For example, we may disclose your health information in response to a court order.

Law Enforcement. We may disclose your health information to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

Deceased Persons. We may disclose your health information to coroners, medical examiners, or funeral directors so that they can carry out their duties.

Organ and Tissue Donation. We may use and disclose your health information to organizations that handle procurement, transplantation, or banking of organs, eyes, or tissues.

Research. Under certain circumstances, we may disclose your health information to researchers who are conducting a specific research project. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

To Avert a Serious Threat to Health or Safety. If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information in a very limited manner to someone able to help lessen the threat.

Teri's Health Services 14040 N. Cave Creek Rd. Suite 205 Phoenix, Az 85022
Office: 602-503-0710 Fax: 602-429-8602

Specialized Government Functions. In certain circumstances, HIPAA authorizes us to use or disclose your health information to authorized federal officials for the conduct of national security activities and other specialized government functions.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or providing for the safety of the correctional institution.

Minors: If you are a minor (17 years old or younger) your guardian has full rights to your charts including all documentation by any provider who provides treatment to you. We are also required to have your guardians sign all paperwork for you to receive treatment and continue treatment, to take medications, to make changes to your treatment, and discharge planning.

Workers' Compensation. We may disclose your health information as necessary to comply with laws related to workers' compensation or other similar programs.

Please be aware that Arizona and other federal laws may have additional requirements that we must follow or may be more restrictive than HIPAA on how we use and disclose certain of your health information. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your health information without your written permission as required by such laws. For example, we will not disclose your mental health or alcohol or drug abuse treatment records without obtaining your written permission, except as permitted by Arizona and federal law. We may also be required by law to obtain your written permission to use and/or disclose your HIV, STD, or other communicable disease related information, developmental disability information, or your genetic test results.

OTHER USES AND DISCLOSURES

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. Some examples include:

- **Psychotherapy Notes:** We will not use and disclose your psychotherapy notes without your written authorization except as otherwise permitted by law.
- **Marketing:** We will not use or disclose your health information for marketing purposes without your written authorization except as otherwise permitted by law.
- **Sale of Your Health Information:** We will not sell your health information without your written authorization except as otherwise permitted by law.

If you change your mind after authorizing a use or disclosure of your health information, you may withdraw your permission by revoking the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your health information that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing to:

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FUNDRAISING

We may use your demographic information (such as name, contact information, age, gender, and date of birth), the dates you received services from us, the department of your service, your treating physician, outcome information, and health insurance status to contact you in an effort to raise money for charitable purposes. We may also disclose this information to a foundation related to Crisis Response Network so that the foundation may contact you to raise money for the foundation. You have the right to opt out of receiving fundraising communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

This section describes your rights regarding the health information we maintain about you. All requests or communications to us to exercise your rights discussed below must be submitted **in writing** to:

Teri's Health Services
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Right to Request Restrictions. You have the right to request restrictions on how your health information is used or disclosed for treatment, payment, or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure of health information to your health insurance company and: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the health information pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid for in full. If we agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate your health information to you in a certain manner or at a certain location. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. We will not ask you the reason for your request.

Right to Inspect and Copy. You have the right to inspect and receive a copy of your health information. We may charge you a fee as authorized by law to meet your request. You may request access to your health information in a certain electronic form and format, if readily producible, or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit such a copy to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. If you are in a facility or group home setting your request for documentation completed by Teri's Health Services can only be requested and provided by Teri's Health Services not directly by your group home or facility placement.

Right to Amend. You have a right to request that we amend or correct your health information that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the



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information be corrected. To request a correction or amendment to your health information, you must make your request in writing and provide a reason for your request. You have the right to request an amendment for as long as the information is kept by or for us. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you. Your request must state a time period which may not go back further than six years. You will not be charged for this accounting, unless you request more than one accounting per year, in which case we may charge you a reasonable cost-based fee for providing the additional accounting(s). We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. A paper copy of this Notice can be obtained from the receptionist at any Crisis Response Network site and is also available at our website at <http://www.crisisnetwork.org>.

COMPLAINTS

You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the Privacy Officer:

Teri's Health Services
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Phoenix, Az 85022

You also have the right to complain to the Secretary of the United States Department of Health and Human Services. **You will not be penalized or otherwise retaliated against for filing a complaint.**

CONTACT INFORMATION

If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact Teri's Health Services directly:

Teri's Health Services
14040 N. Cave Creek Rd. Suite 205
Phoenix, Az 85022
Phone: (602) 503-0710
E-mail: teri@terishealthservices.org



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Teri's Health Services is a mobile and office integrated health care practice that services in home, in office, facility, and group home settings. You are receiving this consent form because you are receiving treatment in one of these settings. You are receiving this consent form because you are currently receiving treatment in a facility based or group home setting. As part of your treatment, Teri's Health Services was hired to provide a service which may include psychiatric, primary care, psychological care, and/or counseling services. Teri's Health Services provides these services as part of a contracted relationship with the facility or group home setting.

Teri's Health Services will bill your insurance directly. You will not receive a bill directly from Teri's Health Services unless first discussed with you any out-of-pocket expense. In order to ensure best practices and Arizona state requirements, Teri's Health Services will exchange protected health information (PHI) with your facility or group home directly to provide coordination of care for you. This means that the facility or group home setting will share your PHI to Teri's Health Services and Teri's Health Services will share your PHI with your facility or group home. As a result, your PHI may be used by the facility or group home for insurance purposes, coordination of care with administrative, case management, and clinical teams, and for placing in their state file in house. If you are in a facility or group home setting your PHI will also be shared with staff and your team in the facility. Your items will also be placed in their electronic health records and/or state files locked in the house/facility as another part of your treatment needs. Teri's Health Services uses their own electronic health record systems separate from that of your facility or group home.

Therefore, each entity will hold your PHI documents. However, only Teri's Health Services can release your documents to you upon request. Your documentation that is completed by Teri's Health Services include such items as: psychiatric and medical evaluation and follow ups, medication records, labs, psychological evaluation. These items will be shared with your facility or group home. You have a right to know what is being shared. You also have the right to refuse treatment at any time.

Patient Print Name:

Patient Signature:

Date:

Guardian 1 Name Print:

Guardian 1 Signature:

Guardian 2 Name Print:

Guardian 2 Signature:

Date:

Date:



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Consent for Purpose of Treatment

I consent to the use and disclosure of _____'s Protected Health Information by Teri's Health Services for the purpose of diagnosing, providing treatment, obtaining payment for health care bills or to conduct health care operations of Teri's Health Services. I understand that the diagnosis or treatment by Teri's Health Services may be conditioned upon the consent as evidenced by the authorizing signature on this document.

Use and disclosure of protected health information is regulated by a federal law known as 'The Health Insurance Portability and Accountability Act of 1996' ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

By signing this consent form I acknowledge receipt of the Notice of Privacy Practices. Furthermore, I am agreeing that Teri's Health Services can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Teri's Health Services is not required to agree to the restrictions that I may request. However, if Teri's Health Services agrees to a restriction that I request, the restriction is binding on Teri's Health Services. I have the right to revoke this consent, in writing, at any time, except to the extent that Teri's Health Services has taken action in reliance on this consent.

The patient's "Protected Health Information" refers health information, including his/her demographic information, collected from the patient and created or received by his/her physician, another health care provider, a health plan, an employer or a health care clearinghouse. This protected health information relates to past, present or future physical or mental health or condition and identifying information, or there is a reasonable basis to believe the information may personally identify the patient named above.

I agree I have reviewed Teri's Health Services Privacy Practices prior to signing this document. Teri's Health Services Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that will occur in treatment, payment of bills, or in the performance of healthcare operations of Teri's Health Services. This Notice of Privacy Practices also describes client rights and Teri's Health Services duties with respect to protected health information.

Teri's Health Services reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing this agreement, I am acknowledging that I have read, understand, and agree to Teri's Health Services Policy and Procedures and Informed Consent regarding facility treatment. A print out of the policies and procedures is available upon request or can be found on terihealthservices.org under Patient Forms.

Patient Print Name:

Patient Signature:

Date:

Guardian 1 Name Print:

Guardian 2 Name Print:

Date:

Guardian 1 Signature:

Guardian 2 Signature:

Date:

Teri's Health Services



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TELEHEALTH SERVICES CONSENT FORM

For medical and psychiatric appointments offered at this time are telemedicine services. These services will be provided via a video and voice call from the screen or phone. There are times when if the video is down the provider will speak to you over the phone about current medication needs and treatment goals. All telemedicine appointments are through a telemedicine online video source that is compliant with state requirements for protection of health information. Upon first starting the telmedicine appointment the provider will ask your name, address, and phone number.

The provider will go over with you the medications you are on, medications being recommended or discontinued, and any symptoms you have. The provider will go over with you your diagnosis and you have a right to ask about your diagnosis in treatment.

The risks of telehealth services includes not having the provider face to face for questions, having psychiatric concerns requiring hospitalizations, or technology failure. In all circumstances you can then reach out to Teri Hourihan practice owner 602-503-0710, speak to your staff if you are at a facility, wait for the provider to call back, or check your email for the next steps to do. If you have an emergency you can call 911 or crisis line. Crisis line: 602-427-4600. If you report an emergency situation to the provider and technology fails the provider will call you back and upon not answering the provider will call 911 and send emergency personnel to your home/facility to help you. In this case we have to break confidentiality to allow for you to be helped.

Once completed for the appointment your provider will speak to the staff at the facility, if you are at a facility or group home setting, and provide them with an overview as well orally and in written form of medication changes. An overview of your session, health, and medication will be provided to your facility for coordination of care. The provider will also discuss with you the after care and needs of care.

You have a right to refuse treatment at any time either orally or in written form.

Patient Print Name:

Patient Signature:

Date:

Guardian 1 Name Print:

Guardian 2 Name Print:

Date

Guardian 1 Signature:

Guardian 2 Signature:

Date:



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Medication Adherence Agreement

We, at Teri's Health Services are committed to doing all we can to treat your illness. In some cases, controlled substances are used as a therapeutic option in the management of anxiety states, insomnia, attention problems, and chronic pain (may be prescribed elsewhere), which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the provider by establishing guidelines, within the laws, for proper and controlled substance use. The words “we” and “our” refer to Teri's Health Services and the words “I,” “you,” “me,” or “my” refer to you, the patient.

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family.
2. I will inform Teri's Health Services of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
3. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering provider, unless specific authorization is obtained for an exception. I understand that I must tell the provider whose signature appears below or, during his/her absence, the covering provider, all medications that I am taking, have purchased, or have obtained. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.
4. I will not seek prescriptions for controlled substances from any other physician or healthcare provider. I understand it is unlawful to be prescribed the same controlled medication by more than one healthcare provider at a time without each provider's knowledge. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a provider, or his/her staff, or knowingly withholding facts from a provider or his/her staff (including failure to inform the provider or his/her staff of all controlled substances that I have been prescribed).
5. I will inform my other healthcare providers that I am taking the controlled substances listed above, and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.
6. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, I will inform Teri's Health Services immediately.
7. I will not allow anyone else to have, sell, use, or otherwise permit others, including spouse or family members, to have access to any controlled substances that I have been prescribed. The sharing of medications with anyone is forbidden and is against the law.
8. I will cooperate with unannounced urine or serum toxicology specimens that may be requested by my provider. Presence of unauthorized substances in urine or serum toxicology screens may result in immediate discharge from Teri's Health Services.

9. I will not consume excessive amounts of alcohol in conjunction with medications. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the provider whose signature appears below or, during his/her absence by the covering provider. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed medication, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
10. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
11. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours, on weekends or holidays.
12. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
13. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
14. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this provider and other providers at Teri's Health Services and that law enforcement officials may be contacted.

I, _____, a patient of [Teri's Health Services] have been informed that individuals who are prescribed medications including, but not limited to, stimulants, sedatives, hypnotics, and benzodiazepine tranquilizers, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing medications to treat my mental health diagnoses.

I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me at my request.

Patient Print Name:

Patient Signature:

Date:

Guardian 1 Name Print:

Guardian 2 Name Print:

Date:

Guardian 1 Signature:

Guardian 2 Signature:

Date:

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Update: 07/16/2020



Purpose: Obtaining legal consent for child and adolescent psychiatric evaluations.

Policy: Decisions about psychiatric, other behavioral health and medical care must be made by the child's legal guardian(s), who must be physically present to provide consent, have an opportunity to be fully informed of the evaluation process, be provided with an opportunity to ask questions, and in order for identity to be verified. In the situation of a parental separation or divorce (except in the case of one parent having sole physical and legal custody), both parents **MUST** consent, in writing, to the psychiatric evaluation, and both parents are invited and encouraged (as they are able) to participate in the process of evaluation and treatment. If one parent retains sole physical and legal custody, this parent **MUST** provide legal documentation of this in order for the psychiatric evaluation to occur as scheduled. Both parents, regardless of custody, have a legal right to medical records.

If services are being rendered to minors, please also provide with forms minor's birth certificate and parental ID to ensure the parents/guardians are requesting the services. If legal documents state one parent is sole guardian please provide these documents as well with enrollment forms.